A Directory of Information and Technical Assistance Resources for State Medicaid Agencies

Medicaid Information and Assistance Project (MIAP)
American Public Welfare Association

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Latest Edition; being updated 11/3/87 mary vellin

Gloria Davis is working with APWA on update. Susan Hanson 7/17/87

Medicaid Information and Assistance Project (MIAP)
American Public Welfare Association

1985-86 Edition

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A RESOURCE DIRECTORY OF INFORMATION AND TECHNICAL ASSISTANCE

AMERICAN PUBLIC WELFARE ASSOCIATION (APWA)
RESEARCH AND DEMONSTRATION DEPARTMENT

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ACKNOWLEDGEMENTS

The Medicaid Information and Assistance Project (MIAP) represents the successful result of a collaborative effort among a number of persons. The American Public Welfare Association (APWA) wishes to acknowledge, with sincere appreciation, the contribution of advice, information and support from the following individuals: members of the MIAP State Advisory Committee; MIAP state contact persons who responded to countless requests for information and assisted in the completion of the MIAP survey; and state Medicaid agency staff, identified as resources in Part IA of this Directory, who generously offered their time and expertise to both project staff and other states.

APWA is also greatly indebted to the following federal staff for the contribution of their time, suggestions and information: Aileen Pagan-Berlucchi, Project Officer for MIAP, Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA); David Baugh, Branch Chief, Medicaid Program Studies Branch, ORD/HCFA; the staff of the Office of Intergovernmental Affairs, HCFA; and the numerous HCFA staff who assisted in the development of the information provided in Part IV of this Directory.

INTRODUCTION

State Medicaid agencies have a need for information and assistance in order to administer their programs in an efficient and effective manner. The complexity of the Medicaid program, financed and regulated by both state and federal government, contributes to the necessity of timely access to information and assistance. As new alternatives to service delivery emerge, as new program requirements are mandated, and as the successes and failures of various cost containment measures are identified, the need for a systematic approach to the delivery and exchange of information and assistance assumes greater importance.

Until a few years ago, the Medicaid/Medicare Management Institute within the Health Care Financing Administration (HCFA) addressed some of the information needs of the state Medicaid agencies. Currently, a variety of information and assistance sources exist, including HCFA grantees and contractors, public policy organizations and the states themselves. However, state Medicaid agencies constantly point to the need, not for more sources of information, but for a systematic approach to locating information in a timely and efficient manner.

For these reasons, the American Public Welfare Association (APWA), through a cooperative agreement awarded by HCFA, has established the Medicaid Information and Assistance Project (MIAP). The purpose of MIAP is to develop and implement a number of mechanisms which will increase state Medicaid agency access to sources of information and assistance and to foster the exchange of information and assistance among the state Medicaid agencies themselves. APWA believes this approach will significantly enhance the use of existing resources related to the Medicaid program.

Contents of the Directory

This MIAP Resource Directory identifies a broad range of information and assistance currently available to state Medicaid agencies from a variety of sources, including the federal government, HCFA grantees and contractors, public policy organizations, university research centers, and state Medicaid agencies. The Directory includes the details on how Medicaid agencies can obtain the information or assistance sources listed, and is structured to allow for easy revision and addition. The Directory is organized into six distinct parts as follows:

PART I - STATE MEDICAID AGENCY RESOURCES

The purpose of this part is to foster the exchange of information, experience and technical assistance among state Medicaid agencies. This part of the Directory is subdivided into two sections:

A. **Staff Resources and Their Areas of Expertise**

This section identifies staff within the various state Medicaid agencies who have expertise in specific program areas and are willing to share their expertise with staff from other states. It is organized into ten broad subject area, such as quality control and reimbursement, and, where appropriate, is further subdivided into more specific program areas.

Within each subject area, the state Medicaid agency staff resources are listed in alphabetical order by state name. The names, addresses and telephone numbers of the staff are listed, in addition to a short description of their area of expertise.

B. **Written Reports and Projects Developed by State Medicaid Agencies**

Reports and studies regularly developed by the state Medicaid agencies and special projects conducted within states can also be a valuable source of information. This section lists these resources identified by state Medicaid agencies in response to a MIAP survey.

The material is organized by subject area and includes information about the availability of the report, how the material may be obtained, and a short description of the contents of each document.

PART II - INDEX OF AVAILABLE INFORMATION AND RESOURCE MATERIAL BY SUBJECT AREA

This index is designed to facilitate state Medicaid agencies' identification of and access to a wide range of currently available published information on Medicaid-related topics. This section is organized by discrete subject areas, such as nursing home reimbursement and prepaid capitation systems, and lists published material from a variety of sources.

Within each subject area, the material is arranged in alphabetical order by author last name and includes information about how to obtain copies of the material, the cost, the date of publication, as well as a brief description of the publication. Installments of this section of the Directory will be issued on a regular basis as the index for each subject area is completed.

PART III - RESEARCH AND DEMONSTRATION PROJECTS IN MEDICAID-RELATED PROGRAM AREAS

The purpose of Part III is to apprise the users of this Directory of recently completed, in progress and upcoming research and demonstration projects in the Medicaid field. The findings obtained through these research projects are often valuable in identifying potential new approaches in areas such as service delivery and cost containment, and in evaluating the benefits and drawbacks of current approaches.

Information in this section will include: a description of the specific area of research, the beginning and ending dates for each project, completed and/or anticipated products, and the name of a contact person to whom further inquiries may be directed.

PART IV - HCFA ORGANIZATIONAL COMPONENTS DEALING WITH MEDICAID PROGRAM AND POLICY ISSUES: FUNCTIONAL RESPONSIBILITIES AND CONTACT PERSONS

This section identifies the appropriate component within the HCFA Central Office (CO) to which state inquiries may be directed concerning specific Medicaid policy and program issues. Following the structure of the HCFA CO

organizational chart as it appears in the Federal Register, each bureau, office or division with responsibility for some aspect of the Medicaid program is identified. Included under each component is a short description of specific Medicaid program-related functions and the type of information and assistance each component can provide to state Medicaid agencies.

The name, address and telephone number to each HCFA CO staff member to whom state inquiries may be directed is identified for each component. Also included is a subject cross-reference index to facilitate the identification of the appropriate HCFA CO component for a particular program area. The subject listings are arranged in alphabetical order.

PART V - MIAP BULLETIN and PART VI - SUPPLEMENTS

These parts provide space within the Directory for state Medicaid agencies to file copies of the monthly MIAP Bulletin and other supplemental information not distributed as part of the Resource Directory.

The MIAP Bulletin will be distributed to state Medicaid agencies on a monthly basis. It will provide information about recently published federal regulations and legislation, court cases, upcoming events and meetings, and will also summarize the outcomes of Technical Advisory Group (TAG) meetings, when appropriate. The Bulletin will also provide other pertinent information not covered within the scope of the Directory.

It is hoped that the contents of the Directory will enable state Medicaid agencies to increase their access to timely information and assistance. The users of the Directory are encouraged to provide MIAP with input and suggestions regarding format and content so that the Directory may be able to keep pace with the information and assistance needs of the state Medicaid agencies.

May 1985

STATE MEDICAID AGENCY RESOURCES

TABLE OF CONTENTS

PART A: STAFF RESOURCES

STATE MEDICAID AGENCY RESOURCES:

PART A

Staff Resources and their Areas of Expertise

I. REIMBURSEMENT

A. Nursing Homes

Florida

Skip Martin
Medicaid Cost Reimbursement
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-9350

- o Cost reimbursement for nursing homes and ICF/MRs.

Illinois

Randall Pletcher
Illinois Department of
Public Aid
628 E. Adams
Springfield, IL 62763
(217) 782-2600

- o Experience in establishing and operating a case-mix reimbursement system; operational since 1978.

Maryland

Joseph M. Millstone, Acting Chief
Division of Long Term Care
Medical Care Programs
300 West Preston Street
Baltimore, MD 21201
(301) 383-2676

- o Rates are determined by need characteristics of individual patients (case mix).

New Hampshire

Paul Casey
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4341

- o N.H. currently uses a cost-related prospective system, however, the state is considering adopting a case-mix prospective system and is conducting research in that area.

Rhode Island

Henry Godin, Assistant Administrator
Division of Medical Services
Dept. of Social and Rehabilitative Services
600 New London Avenue
Cranston, RI
(401) 464-2311

- o Prospective reimbursement for ICFs and SNFs

Texas

Bob Conkright
Texas Department of Human Resources
P.O. Box 2960
Austin, TX 78769
(512) 450-4046

- o Conducting 3 year research project analyzing various case mix reimbursement models including those based on: ADL, DRG-type and statistical concept.

  *will also discuss reimbursement theories and systems in a wide range of other program areas.

Utah

Roy Dunn, Reimbursement Specialist
Division of Health Care Financing - Policy
and Planning
P.O. Box 45500
Salt Lake City, UT 84145-0050
(801) 533-6149

- o Development of flat rate reimbursement rates for nursing homes (with minor variances for property costs).

B. Hospital

California

Ron Klusman, Chief
Hospital Contracts Coordination Section
Medi-Cal Operations Division, DHS
California Department of
Health Services
714 P Street, Room 1540
Sacramento, CA 95814
(916) 322-2334

- Selective hospital contracting through a special negotiator

Illinois

Michael Taylor
Illinois Department of
Public Aid
931 E. Washington
Springfield, IL 62763
(217) 785-1647

- Experience related to establishment of hospital rates on a negotiated or competitive basis rather than a cost-related basis, including obtaining waivers for competitive contracting, establishing data basis, developing negotiating teams and implementing the contract; implemented in 1985.

Minnesota

Thomas Joli Cover
Minnesota Dept. of Human Services
444 Lafayette Rd.
St. Paul, MN 55101
(612) 297-2022

- Has developed a modified DRG reimbursement system using Medicaid-specific rates. Will be implemented August 1, 1985.

New Hampshire

Leslie Kaplan Melby
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4352

- o New Hampshire has entered into a contract with the University of New Hampshire for assistance in determining the feasibility of implementing DRGs. Using historical data, a forecasting model will be developed which will enable the state to determine the potential impact of various alternatives prior to implementation.

North Carolina

Mike Karpinski
North Carolina Division
of Medical Assistance
410 North Boylan Avenue
Raleigh, NC 27603
(919) 733-6784

- o Per diem rate system
- o Research on DRGs

Ohio

Kathryn Glynn, Assistant Deputy Director
Office of Medicaid Administration
Ohio Dept. of Human Services -33rd Floor
30 East Broad St.
Columbus, OH 43215
(614) 466-3196

- o DRGs

Oregon

Hersh Crawford
Chad Cheriel
Adult and Family Services
Health Services Section
Department of Human Services
203 Public Service Building
Salem, OR 97310
(503) 378-2762

- o DRGs

Pennsylvania

David Ulsh
Department of Public Welfare
Office of Medical Assistance
Bureau of Policy and Program Development
Room 510, Health and Welfare Building
Harrisburg, PA 17120
(717) 787-1170

- o DRGs

Washington

Tom Bedell
Management and Rate Analysis
Section LE-11
Department of Social and
Health Services
Olympia, WA 98504
(206) 754-2588

- o DRGs

C. Pharmacy

Kansas

Gene Hotchkiss
Department of Social &
Rehabilitation Services
Room 628 S
State Office Bldg.
Topeka, KS 66612
(913) 296-3981

- o Elements of reimbursement system include:
  - variable cost-related dispensing fee
  - estimated acquisition cost system determined by state pharmacists with some referral to Red Book
  - successful copayment program
  - drug utilization review program

New Jersey

Sanford Luger, R.Ph.
Division of Medical Assistance
and Health Services
CN712
Trenton, NJ 08625
(609) 292-3756

- o Capitation of pharmaceutical services in long-term care facilities.

Rhode Island

John Pagliarini
Assistant Administrator
Division of Medical Services
Department of Social and
Rehabilitative Services
600 New London Avenue
Cranston, RI 02920
(401) 464-2184

- o Heavily computerized program

II. WAIVERS

A. Home and Community-Based Care (2176)

Kansas

Janet Schalansky
Biddle Bldg. - First Floor
2700 W. 6th Street
Topeka, KS 66606
(913) 296-3981

- Waivers for elderly and mentally retarded covering 11 different services

Maine

Christine Zukas-Lessard
Acting Director
Cost Containment Division
Bureau of Medical Services
Department of Human Services
State House Station #11
Augusta, ME 04333
(207) 289-2674

- Services to the elderly, mentally retarded and handicapped.

Missouri

Leslie Jordon
Department of Social Services
Division of Medical Services
308 East High Street
Jefferson City, MO 65101
(314) 751-3277

- Elderly population
- Third year of implementation
- Request for three year renewal is currently being reviewed by HCFA
- Services include homemaker, chore, respite and case management

Ron Meyer
Division of Medical Services
308 East High Street
Jefferson City, MO 65101
(314) 751-3277

- Services to disabled children under the age of 21

New Hampshire

Eileen Doole
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4339

- Elderly, chronically ill.

Diane McFall
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4354

- Developmentally impaired.

New Jersey

Carol Kurland
Office of Home Care Programs
Division of Medical Assistance and
Health Services
CN712
Trenton, NJ 08625
(609) 292-1940

- Community care programs for the elderly and disabled. Also several "model" waiver programs for blind and disabled children and adults.

North Carolina

Jim Dunn
North Carolina Division of Medical Assistance
410 North Boylan Avenue
Raleigh, NC 27603
(919) 733-6775

- Two waivers:
  - developmentally disabled/mentally retarded
  - elderly

Rhode Island

Lewis Treistman, Assistant Administrator
Division of Medical Services
Dept. of Social and Rehabilitative Services
600 New London Avenue
Cranston, RI 02920
(401) 464-3496

- Three waivers providing services to:
  - the elderly and disabled
  - the chronically mentally ill
  - the mentally retarded

South Carolina

Samuel T. Waldrep, Acting Director
Health and Human Services Finance Commission - CLTC
P.O. Box 8206
Columbia, SC 29202-8206
(803) 758-2921

- HCBC services for Medicaid eligible persons with long term care needs
- Pre-admission screening for nursing home care
- Comprehensive statewide system of case management
- Services include:
  - personal care
  - medical day care
  - physical, speech & occupational therapy
  - case management
  - respite care
  - home delivered meals
  - medical social services

B. **Freedom of Choice (2175)**

Colorado

Bev Thurber
Dann Milne
Colorado State Department of
Social Services
1575 Sherman - Room 1004
Denver, CO 80203
(303) 866-2142

- o Statewide primary care physician program using case management

Kansas

Joyce Sugrue
Department of Social and
Rehabilitation Services
State Office Bldg. - Room 628S
Topeka, KA 66612
(913) 296-3981

- o Primary care network system featuring:
  - mandatory enrollment for all programs and all eligibles
  - fee-for-service with payment for case management
  - have submitted request to review waiver to delete rural areas

Oregon

John Hutchinson
Chad Cheriel
Department of Human Services
Adult and Family Services
Health Services Section
203 Public Service Building
Salem, OR 97310
(503) 378-5581

- o AFDC recipients residing in the Greater Portland Metropolitan area will be required to receive Medicaid services from one of 9 Physician Care Organizations (PCOs) or a federally qualified HMO. Upon implementation the fee-for-service system of reimbursement for Medicaid services will be suspended in those areas.

C. Demonstration (1115)

Missouri

Helen Clarkston
Department of Social Services
Division of Medical Services
308 East High
Jefferson City, Missouri 65101
(314) 751-2895

- o prepaid health plan
- o limited to AFDC-only residing in Kansas City area
- o clients may select either (1) one of 5 prepaid health plans; or (2) a physician sponsor

New Hampshire

Diane Peterson
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4365

- o HUD Demonstration Project serving the chronically and severely mentally ill. Services provided include case management, transportation, life skill training, supervision and dental care.

III. ALTERNATIVE DELIVERY MECHANISMS

A. Prepaid Capitation - HMOs

California

James N. Taylor, Chief
Provider Rate Section
Medi-Cal Policy Division
Department of Health Services
714 P Street, Room 1560
Sacramento, CA 95814
(916) 445-8128

- o Development of actuarially-determined rates for capitated providers

Denise Wilson
Capitated Health Systems Section
Medi-Cal Operations Division
Department of Health Services
714 P Street, Room 1400
Sacramento, CA 95814
30 East Broad Street
(916) 323-2247

- o Handles membership payments to capitated providers
- o Collects data on characteristics of recipients enrolled in capitated systems
- o Handles enrollment/disenrollment documents and activities

New Hampshire

Diane Kemp
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4362

New Jersey

S. Eugene Yuliano, M.D. or Jill Simone, M.D.
Office of Prepaid Health
Division of Medical Assistance and
Health Services
CN712
Trenton, NJ 08625
(609) 292-8158

- o Prepaid capitation programs; competition programs and HMO development. Also quality assurance systems in an ambulatory setting.

Ohio

Jim Burnosky, Administrative Assistant
Office of Medicaid Administration
Ohio Dept. of Human Services - 33rd Floor
30 East Broad Street
Columbus, OH 43215
(614) 466-3196

- o Development of HMO resources

Wisconsin

Tom Lovett
Wisconsin Department of
Health and Social Services
Bureau of Health Care Financing, Room 265
P.O. Box 309
Madison, WI 53701

- o Implemented HMO enrollment initiative in select areas of the state for AFDC recipients. Has resulted in the development of new HMOs.

B. Case Management

Illinois

Connie Cheren
Illinois Department of Public Aid
931 E. Washington
Springfield, IL 62763
(217) 782-0545

- o Experience establishing case managers with responsibility for overseeing the delivery of long term care to Medicaid clients, including the development of job descriptions and hiring qualified nursing staff, establishment of information systems to monitor performance of staff, and development of financial incentives to enforce case management decisions.

C. Other

New Jersey

George Logusch, Ph.D.
Office of Prepaid Health Care
Division of Medical Assistance and
Health Services
CN712
Trenton, NJ 08625
(609) 292-8158

- Expenditure forecasting systems for alternative reimbursement methodologies.

Washington

Gaylan Gaither
Department of Social and
Health Services
Managements and Rate Analysis, Section LE-11
Olympia, WA 98504
(206) 754-2587

- Contractual arrangements with single source provider for select services e.g. eyeglasses, oxygen services.

IV. UTILIZATION CONTROL AND REVIEW

A. Recipient Lock-In

Nebraska

Tom Dolan, R.Ph.
Nebraska Department of Social Services
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-3121

- Long established system which locks-in recipients to a hospital, physician or pharmacy or any combination of these 3 providers.

Ohio

Bob Lewis, Chief
Bureau of Surveillance and Utilization Review
Ohio Dept. of Human Services - 31st Floor
30 East Broad St.
Columbus, OH 43215
(614) 466-7936

Pennsylvania

Fortuna Lewis
Department of Public Welfare
Office of Medical Assistance
Bureau of Utilization Review
25 North 32nd Street
Camp Hill, Pennsylvania 17011
(717) 787-3455

- Through S/URS identifies overutilizers through review of the paid claims history.

Washington

Steven Roehrs
Department of Social and
Health Services
Recipient Review Unit LE-11
Olympia, WA 98504
(206) 754-2600

B. Hospital Utilization Control and Review

Connecticut

Laura Dunston
Connecticut State Department
of Income Maintenance
110 Bartholomew Avenue
Hartford, CT 06106
(203) 566-2132 (2144)

- o Hospital Utilization Review Program using an appropriateness Evaluation Protocol, severity of illness and intensity of service criteria.

Maryland

Larry Payne, Director
Department of Health and
Mental Hygiene
Medical Assistance Compliance Administration
Medical Care Programs
300 West Preston Street
Baltimore, MD 21201
(301) 383-6367

- o Review package consists of:
  - list of procedures which can be reimbursed only if performed on an outpatient basis
  - procedures for which one pre-operative day is allowed
  - 100% Medical Record review
  - pre-authorization of all elective surgery

  (Note: Blue Cross of MD is adopting this package for its hospital review program)

Michigan

Dr. Robert Levin, Director
Bureau of Health Services Review
Medical Services Administration
Department of Social Services
P.O. Box 30037
Lansing, MI 48910
(517) 373-7510

- o Requires prior authorization for all elective hospital care. Has reduced inpatient utilization

Oregon

Cliff Greenlick
Department of Human Services
Adult and Family Services
Health Services Section
203 Public Service Building
Salem, OR 97310
(503) 378-5581

- o Review package includes:
  - Pre-admission screening
  - Mandatory second surgical opinion
  - Prepayment review of emergency admissions

Pennsylvania

Joyce Grix
Department of Public Welfare
Office of Medical Assistance
Bureau of Utilization Review
25 North 32nd Street
Camp Hill, PA 17011
(717) 787-3455

- o Inpatient hospital care monitoring through DRG outlier review and admissions review for providers still under a retrospective reimbursement system

Virginia

Doctor Stephen Riggs
Director, Health Services Review
Department of Medical Assistance Services
109 Governor Street
Richmond, VA 23219
(804) 786-3820

- o State-administered hospital utilization review program.

C. Other

District of Columbia

Francine Towns
Specialist Assistant
Office of Health Care Financing
1331 H Street, N.W., Suite 500
Washington, D.C. 20005
(202) 727-9693

- o Utilization Control in small Intermediate Care Facilities for the Mentally Retarded

Iowa

Gary Gesaman
Bureau of Medical Services
Iowa Department of Human Services
5th Floor, Hoover Building
Des Moines, IA 50319
(515) 281-5586

- o Use of PRO for utilization review and quality of care programs.

Michigan

Dr. Robert Levin, Director
Bureau of Health Services Review
Medical Services Administration
Department of Social Services
P.O. Box 30037
Lansing, MI 48910
(517) 373-7510

- o Highly computerized drug utilization review system which profiles recipients and providers for identification of potential abuse

- o Also identifies patterns of recipient drug use and physician prescription patterns to determine if interaction of drugs may cause physical problems or unnecessary hospitalization

Pennsylvania

James Pezzuti
Department of Public Welfare
Office of Medical Assistance
Bureau of Medical Assistance Operations
Room 95, Park Penn Building
Harrisburg, PA 17112
(717) 657-4359

- o Inspection of Care for recipients in nursing homes

V. QUALITY CONTROL

North Carolina

Linda Connelly
North Carolina Division of Medical Assistance
410 North Boylan Avenue
Raleigh, NC 27603
(919) 733-3590

- Corrective Action
  Quality control in the Claims Processing Assessment System

Texas

Tim Varian
Texas Department of Human Resources
P.O. Box 2960
Austin, TX 78769
(512) 465-1138

- Through the MQC-CPAS system and retrospective eligibility review, Texas recoups significant misspent dollars due to incorrect eligibility determination. Includes identification of dually-eligible Medicare receipents and recoupment from Medicare carriers and intermediaries.

VI. THIRD PARTY LIABILITY AND RECOVERY

Iowa

(General Information)
Stan Monroe
Bureau of Medical Services
Hoover State Office Building
Des Moines, IA 50319
(515) 281-8433

(Information re: Computer Match)
Ray Camp
Director of Data Processing
Iowa Department of Human Services
5th Floor, Hoover Building
Des Moines, IA 50319
(515) 281-8708

- Computer match of Job Service employer files and social security numbers of absent parents whose children receive Medicaid.

Maine

Hilary Fleming, Director
Medical Claims Review Division
Bureau of Medical Services
Department of Human Services
State House Station #11
Augusta, ME 04333

Michigan

Richard Maharan, Director
Bureau of Fiscal Review
Medical Services Administration
Department of Social Services
P.O. Box 30037
Lansing, MI 48910
(517) 373-8276

- Uses both "cost avoidance" and "pay and chase" methods
- Has low administrative cost per dollar collected or avoided
- In final stage of developing a system to track dollars amounts associated with cost avoidance
- Has information on techniques/approaches/staffing strategies.

New Hampshire

Susan Hebert
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4393

North Carolina

Don Best
North Carolina Division of Medical Assistance
410 North Boylan Avenue
Raleigh, NC 27603
(919) 733-6294

Pennsylvania

Edgar Barrett
Department of Public Welfare
Office of Medical Assistance
Bureau of Medical Assistance Operations
Room 95, Park Penn Building
1501 Jonestown Road
Harrisburg, PA 17112
(717) 657-4054

VII. ELIGIBILITY AND COVERAGE

A. Medically Needy Eligibility and Spend Down

Hawaii

Winifred Odo
Field Service Representative
Medical Care Administration Office
Department of Social Services & Housing
P.O. Box 339
Honolulu, HI 96809
(808) 548-8918

Minnesota

Mary Kennedy
Minnesota Department of Human Services
444 Lafayette Street
St. Paul, MN 55101
(612) 297-3200

B. Organ Transplants

New Jersey

Margaret Kerchner
Division of Medical Assistance and
Health Services
CN712
Trenton, NJ 08625
(609) 292-4656

Wisconsin

Alfred Dally, M.D.
Wisconsin Department of Health
and Social Services
Bureau of Health Care Financing
Room 239
P.O. Box 309
Madison, WI 53701
(608) 266-0957

- Cost and Quality/Success information

C. **Medicare Buy-In**

Hawaii

Richard Isa
Field Service Representative
Medical Care Administration Office
Department of Social Services & Housing
P.O. Box 339
Honolulu, HI 96809
(808) 548-8916

D. **EPSDT**

New Jersey

Ruth Stekert, M.D.
Child Health Services
Division of Medical Assistance and
Health Services
CN712
Trenton, NJ 08625
(609) 292-8197

- Development and utilization of "Clown Show" (both live and film) for recipient education in the EPSDT program.
- General questions related to school health and EPSDT Equivalency programs.

South Carolina

James E. Jollie, Director
Preventive Care Division
Health and Human Services Finance Commission
P.O. Box 8206
Columbia, SC 29202-8206
(803) 758-8693

- Cost containment and program initiatives in dental care
- Volume purchasing under vision care

E. Non-institutional Long-Term Care

New Jersey

Carol Kurland
Office of Home Care Programs
Division of Medical Assistance
and Health Services
CN712
Trenton, NJ 08625
(609) 292-1940

- Adult day care and personal care services.

F. Recipient Appeals

Virginia

Ann Cook, Director
Medical Social Services
109 Governor Street
Richmond, VA 23219
(804) 786-4995

- Recipient appeals.

G. General

Maine

Judy Williams
Director, Medicaid Eligibility
Bureau of Income Maintenance
Department of Human Services
State House - Station #11
Augusta, ME 04333
(207) 289-2826

- Handles a range of Medicaid and public assistance eligibility issues including the areas of categorically and medically needy and catastrophic illness.

Utah

Robert Knudson, Planner
Division of Health Care Financing
Policy and Planning
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 533-6149

- Handles a broad range of Medicaid-related eligibility questions and issues.

VIII. AUTOMATED SYSTEMS

A. MMIS (General)

Florida

Karin Morris
Medicaid Contract Management
2671 Executive Center Circle West
Koger Center
Webster Building, Room 311
Tallahassee, FL 32301
(904) 488-0530

- o MMIS operations including procurement, evaluation of proposals and acceptance testing.

Maine

Hilary Fleming, Director
Medical Claims Review Division
Bureau of Medical Services
Department of Human Services
State House Station #11
Augusta, ME 04333
(207) 289-3081

- o Implementation of MMIS and development of utilization reports.

Nebraska

Maureen Murray
Nebraska Department of Social Services
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-3121

- o Developed in-house system which has been operational for more than 7 years.

New Hampshire

Robert Moore
New Hampshire Division of Welfare
Office of Medical Services
Hazen Drive
Concord, NH 03301
(603) 271-4258

- o In midst of conversion to fiscal agent.

New Jersey

William J. Corboy, Chief
Bureau of Management Information Systems
Division of Medical Assistance and
Health Services
CN712
Trenton, NJ 08625
(609) 292-8850

- o Eligibility subsystems and data base application for Medicaid claims within the MMIS.

Vermont

James L. Barre
Medicaid Division
Department of Social Welfare
103 South Main Street
Waterbury, VT 05676
(802) 241-2880

- o MMIS Contracting

Jeanne Ladd
Medicaid Division
Department of Social Welfare
103 South Main Street
Waterbury, VT 05676
(802) 241-2880

- o MMIS Contract Monitoring

B. S/URS (Also see IV. Utilization and Control Review)

Kansas

Sandra Stallbaumer
Department of Social and
Rehabilitation Services
State Office Building - Room 628S
Topeka, KS 66612
(913) 296-3981

- o Cooperative effort with the Fraud Unit to identify and refer for follow-up cases of fraud and abuse

- o All ancillary services in general hospitals, including in-patient and out-patient services, are reviewed

Minnesota

James Campbell
Minnesota Department of
Human Services
444 Lafayette Road
St. Paul, MN 55101
(612) 297-1081

- o S/URS II system

Pennsylvania

Fortuna Lewis
Department of Public Welfare
Office of Medical Assistance
Bureau of Utilization Review
25 North 32nd Street
Camp Hill, PA 17011
(717) 787-3455

- o Coordinates S/URS control file and determines parameters. Generate profiles to identify overutilizers

C. Claims Processing

Guam

Jaime Montano
Medicaid Program
Department of Public Health &
Social Services
Post Office Box 2816
Agana, GU 96910
(671) 734-2944

- o Computerized claims processing

Pennsylvania

Robert Kelly
Department of Public Welfare
Office of Medical Assistance
Bureau of Medical Assistance Operations
Room 95, Park Penn Building
1501 Jonestown Road
Harrisburg, PA 17112
(717) 657-4212

- o Uses a "hybrid" system consisting of:
  - fiscal agent for handling manual functions such as: opening claims; edit resolution; microfilming; and data entry
  - in-house, state-operated computer operation including all MMIS subsystems

D. Automated Eligibility Systems

Maryland

Melvina Ford, Acting Director
Department of Health and
Mental Hygiene
Medical Assistance Operations Administration
Medical Care Programs
201 West Preston Street
Baltimore, MD 21201
(301) 383-2628

- o Automated eligibility verification system

Wisconsin

Rich Pederson
Wisconsin Department of Health
Social Services
Division of Community Services, B-103
1 West Wilson Street
Madison, WI 53701
(608) 267-7629

- o Automated eligibility determination system
- o Conducts in-house computerized front-end eligibility review after the counties do the initial eligibility determinations.

IX. PROGRAM INTEGRITY/FRAUD AND ABUSE

Colorado

Marianne Seddon
Colorado Department of Social Services
1775 Sherman - Room 911
Denver, CO 80203
(303) 866-3440

- o Provider fraud and abuse

Florida

Robert Pierce
Medicaid Program Integrity
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 487-1090

- o Fraud and abuse investigation and recovery.

Pennsylvania

Glenn Johnson
Department of Public Welfare
Office of Medical Assistance
Bureau of Utilization Review
25 North 32nd Street
Camp Hill, PA 17011
(717) 787-3455

- o General issues

John Ferrara
Department of Public Welfare
Office of Medical Assistance
Bureau of Utilization Review
25 North 32nd Street
Camp Hill PA 17011
(717) 787-3455

- o Provider enforcement activities for all categories of providers other than hospitals and nursing homes. Identification of providers for possible termination from program.

X. OTHER

A. State Health Planning and Certificate of Need

Alabama

Mike Murphy, Director
Planning and Research
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, AL 36130
(205) 277-2710

- Efforts to limit and control expansion of beds and services.

B. Hospital Cost Reporting and Auditing

Alabama

Susan Mims, Director
Provider Audit and Reimbursement Division
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, AL 36130
(205) 277-2710

- Alabama is in the process of developing a unique system of cost reporting and auditing. It will be a prospective reimbursement system for in-patient hospital care with the state conducting its own internal auditing. It is currently in the research and development stage with implementation anticipated in January 1986.

C. Co-Payments

Colorado

Bev Thurber
Dann Milne
Colorado State Department of
Social Services
1575 Sherman - Room 1004
Denver, CO 80203
(303) 866-2142

- o The following services require co-payments: physician services, in-patient hospital services, out-patient hospital services, community mental health services, and pharmacy services

D. Provider Appeals

Colorado

Dean Woodward
Colorado State Department of
Social Services
1575 Sherman - Room 909
Denver, CO 80203
(303) 866-5185

- o Special unit created to assist providers with resolution of eligibility issues and problems with fiscal agent so that their claims can be paid; providers include hospitals, physicians, and pharmacies; do not deal with long term care rate adjustments.

E. Nutrition Therapy

District of Columbia

Janice Anderson, Chief
Program Operations
Department of Human Services
1331 H Street, N.W., Suite 503
Washington, D.C. 20005
(202) 727-0729

- o Intraveneous Parenteral and Enteral Nutrition Therapy in home-based settings

STATE MEDICAID AGENCY RESOURCES

TABLE OF CONTENTS

PART B: WRITTEN REPORTS AND PROJECTS

STATE MEDICAID AGENCY RESOURCES:

PART B

Written Reports and Projects

I. REIMBURSEMENT

A. Nursing Homes

Maryland

"Nursing Home Reimbursement Regulations"
1985

- o SNF and ICF regulations for patient-specific system of nursing home reimbursement.

- o Additional information and/or copies may be obtained from:

  Joe Millstone
  Acting Chief
  Division of Long Term Care
  Medical Care Programs
  300 West Preston Street
  Baltimore, MD 21201
  (301) 383-2676

Nebraska

"Report on the Development of a Medicaid Rate-Setting Methodology for Intermediate Care Facility Services"
November 1983

- o Development of an ICF/MR payment methodology based upon a reasonable personnel cost model; results of a National Survey of States' ICF rate-setting methodologies.

- o Additional information and/or copies may be obtained from:

  Nebraska Department of Social Services
  301 Centennial Mall South
  Lincoln, NE 68509
  (402) 471-3121

Texas

"Long-Term Care Case Mix Reimbursement Project"
(Implementation: July 1985)

- Two year planning and research project funded by HCFA to: (1) develop a patient assessment instrument for use in case mix determination; (2) assess case mix indices and methodologies developed in other states; (3) develop the most appropriate reimbursement methodology; and (4) plan a demonstration which will test the effectiveness and efficiency of the new system in a sample of nursing homes.

- Additional information and/or copies may be obtained from:

  Robert Conkright
  Texas Department of Human Resources
  P.O. Box 2960
  Austin, TX 78769
  (512) 450-4046

B. Hospital

Indiana

"Report to the Legislature: Hospital Prospective Payment Study Commission (HPPSC)"
December 31, 1984

- The HPPSC has been charged with the responsibility to study:

  - a prospective payment system for hospital care based on criteria that encourage cost containment while maintaining adequate levels of care

  - cost differences among all payors including Medicare, Medicaid and private insurers

  - the impact of federal policy and budget changes

  - the role of alternative delivery systems in reducing health care costs

- Additional information and/or copies may be obtained from:

  Donald Blinzinger, Chairman
  Hospital Prospective Payment Study Commission
  Indiana State Department of Public Welfare
  100 No. Senate Avenue
  Room 701
  Indianapolis, IN 46204
  (317) 232-4359

Ohio

"Overview of the Ohio Medicaid Prospective Payment System"
September 1984

- Overview of the rules governing Ohio's diagnosis-specific prospective payment system.

- Additional information and/or copies may be obtained from:

  Kathryn Glynn
  Assistant Deputy Director
  Office of Medicaid Administration
  Ohio Department of Human Services
  30 East Broad St., 33rd floor
  Columbus, OH 43215
  (614) 466-3196

Oregon

"Hospital Inpatient Prospective Reimbursement Feasibility Study: Detailed Implementation Plan"
(Still in progress).

- DRG reimbursement.

- Study still in progress; related documents and information available from:

  Adult and Family Services
  Health Services Section
  203 Public Service Building
  Salem, OR 97310

  Hersh Crawford (503) 378-2762 or
  Chad Cheriel (503) 378-5581

Washington

"The State of Washington Medical Assistance Program Diagnosis Related Group-Based Prospective Payment System for Inpatient Hospital Care"
January 1985

- Describes Washington's DRG system.

- Additional information and/or copies may be obtained from:

  Management and Rate Analysis
  Section LE-11
  Department of Social and Health Services
  Olympia, WA 98504

C. Pharmacy

New Jersey

"An Alternative Reimbursement System to Encourage Optimum Pharmacy Services"
July 1984

- Article appearing in the July 1984 issue of American Health Care Association Journal describes two methods of capitation for pharmaceutical services. Also discusses drug utilization review in terms of its importance to a successful capitation program.

- Additional information and/or copies may be obtained from:

Sanford Luger, R.Ph.
Division of Medical Assistance
and Health Services
CN 712
Trenton, NJ 08625
(609) 292-3756

II. WAIVERS

A. Home and Community-Base Care (2176)

Kansas

"Home and Community-Based Care Services"
April 1984

- An analysis of: services provided and costs incurred, compared to institutional long-term care services; characteristics of recipients and services; client satisfaction with HCBCS; ability of HCBCS to prevent institutionalization.

- Additional information and/or copies may be obtained from:

  Mark Levy
  Social and Rehabilitation Services
  Office of Analysis, Planning and Evaluation
  State Office Building
  Topeka, KS 66612
  (913) 296-3765

North Carolina

"Medicaid Community Alternatives Handbook"
November 16, 1983

- Policies and procedures for providing home and community based services.

- Additional information and/or copies may be obtained from:

  Jim Dunn
  North Carolina Division of Medical Assistance
  1985 Umstead Drive
  Raleigh, NC 27603
  (919) 733-6775

B. Freedom of Choice (2175)

Colorado

"Primary Care Physician Program Evaluation"
May 1985

- State is nearing the end of a two year Freedom of Choice waiver for a Primary Care Physician program, which they hope to extend. A study has been completed which compares utilization patterns before and after implementation of the program.

- Additional information and/or copies available from:

  Dean Woodward
  Manager of Physicians Services Section
  Medical Services Division
  Colorado State Department of
  Social Services
  1575 Sherman Street
  Denver, CO 80203
  (303) 866-3032

Wisconsin

"A Report on the Effects of the Medical Assistance Mental Health Gatekeeper Program"
August 1984

- Under Wisconsin's Mental Health Gatekeeper Program (implemented under a 2175 Freedom-of-Choice waiver), community mental health boards must authorize mental health, alcohol and other drug abuse services for Medicaid recipients. This report evaluates the program over a three year period, including the effect on costs, utilization of services, cost shifting and access to services as well as looking at the effectiveness of various types of boards.

- Additional information and/or copies may be obtained from:

  Tim Tyson
  Division of Policy and Budget
  Wisconsin Department of Health
  and Social Services
  P.O. Box 7850
  Madison, WI 53707
  (608) 266-9336

III. ALTERNATIVE DELIVERY MECHANISMS

A. Prepaid Capitation - HMOs

New York

"Report to the Legislature on the Implementation of the Medicaid Reform Act of 1984"
January 15, 1985

- Report on state legislation in Medicaid program areas including the development of three programs: Prepaid Health Services Plans, Physician Case Management Program and the enhancement of office-based primary care physician and dental fee schedules.

- Additional information and/or copies may be obtained from:

  Norma Nelson
  Assistant Commissioner
  for Medical Assistance
  New York State Department of
  Social Services
  40 North Pearl Street
  Albany, NY 12243
  (518) 473-5611

Ohio

"An Introduction to Serving the Medicaid Population for Health Maintenance Organizations"
March 1985

- A guide for HMOs considering contracting with Ohio's Medicaid program to provide services, including: information about Medicaid; HMO licensure and requirements; data regarding the Medicaid benefit package; recipient characteristics; service utilization; and rate setting.

- Additional information and/or copies may be obtained from:

  Jim Burnosky
  Administrative Assistant
  Office of Medicaid Administration
  Ohio Department of Human Services
  30 East Broad St., 33rd floor
  Columbus, OH 43215
  (614) 466-3196

Oregon

"Prepaid Capitated Health System"
(Still in progess)

- o Prepaid capitation system implementation.

- o Implementation still in progress; implementation plan, contracts, RFPs and other related documents and information available from:

  John Hutchinson
  or
  Chad Cheriel
  Adult and Family Services
  Health Services Section
  203 Public Service Building
  Salem, OR 97310
  (503) 378-5581

Washington

"Managed Health Care Systems and Health Maintenance Organization Enrollment"
January 1, 1985

- o Efforts to increase recipient enrollment in HMOs and other managed health care systems.

- o Additional information and/or copies may be obtained from:

  Management and Rate Analysis
  Section LE-11
  Department of Social and Health Services
  Olympia, WA 98504

B. Case Management

Kansas

"Primary Care Network Program"
February 1985

- o The results of a study to determine if Kansas' Primary Care Network Program is meeting its goals of improving client access to medical care, reducing unnecessary utilization of emergency room and other services, and reducing overall Medicaid expenditures. Also includes clients' and providers' opinions about the program.

- o Additional information and/or copies may be obtained from:

  Mark Levy
  Social and Rehabilitation Services
  Office of Analysis, Planning and Evaluation
  State Office Building
  Topeka, KS 66612
  (913) 296-3765

New York

"Report to the Legislature on the Implementation of the Medicaid Reform Act of 1984"
January 15, 1985

- Report on state legislation in Medicaid program areas including the development of three programs: Prepaid Health Service Plans, Physician Case Management Program and the enhancement of office-based primary care physician and dental fee schedules.

- Additional information and/or copies may be obtained from:

  Norma Nelson
  Assistant Commissioner
  for Medical Assistance
  New York State Department of
  Social Services
  40 North Pearl Street
  Albany, NY 12243
  (518) 473-5611

Wisconsin

"Community Options Program: An Evaluation of Early Implementation Experience"
January 1983

"Community Options Program: Overview of Early Evaluation Findings"
January 1983

"Summary Statistical Data on Community Options Program Operated in 1982"
February 1984

"Community Options Program: An Evaluation of Program Operations During 1982 and 1983"
December 1984

- The Community Options program was developed as a precursor to a home and community-based services waiver application. This program focused on diverting recipients from nursing homes into community settings, was implemented statewide and utilized $50 million annually. The purpose of the program was to place chronically disabled persons in community settings as appropriate.

- Additional information and/or copies may be obtained from:

  Tim Tyson
  Division of Policy and Budget
  Wisconsin Department of Health
  and Social Services
  P.O. Box 7850
  Madison, WI 53707
  (608) 266-9336

IV. UTILIZATION CONTROL AND REVIEW

Connecticut

"Long-Term Care Pre-Admission Screening Report to the Connecticut General Assembly"
December 5, 1984

- Report on a study required by the state General Assembly to determine the potential effects of pre-admission screening of applicants to long-term care facilities, including a review of existing programs in other states and recommendations for a program in Connecticut.

- Additional information and/or copies may be obtained from:

  Bill Diamond
  Income Maintenance
  Medical Program Manager
  Department of Income Maintenance
  110 Bartholomew Avenue
  Hartford, CT 06106
  (203) 566-2045

District of Columbia

"Analysis of Selected Medicaid Drug Utilization and Recipient Management Programs"
April 1984

- Analysis of programs to control drug utilization.

- Additional information and/or copies may be obtained from:

  Francine Towns
  Special Assistant
  Department of Human Services
  1331 H Street, N.W., Room 500
  Washington, DC 20005
  (202) 727-9693
  or
  Pracon, Incorporated
  10390 Democracy Lane
  Fairfax, VA 22030
  (703) 691-0762

Missouri

"Pre-Admission Screening Survey: Survey Results"
January 1984

- Review of pre-admission screening procedures used in 22 states.

- Additional information and/or copies may be obtained from:

  Tammy Babcock
  Department of Social Services
  Division of Medical Services
  308 East High St.
  P.O. Box 88
  Jefferson City, MO 65103
  (314) 751-3277

Oregon

"Hospital Utilization Control: Implementation Plan, PRO Contract, Data Reports, Related Documents"
1983-1985 (In progress)

- Publication contains various materials related to Oregon's hospital utilization control program which includes: preadmission screening, mandatory second surgical opinion, and prepayment review of emergency admissions.

- Additional information and/or copies may be obtained from:

  Cliff Greenlick
  Adult and Family Services
  Health Services Section
  203 Public Services Building
  Salem, OR 97310
  (503) 378-5581

Wisconsin

"Surgery Rates Under the Medicaid Second Surgical Opinion Program"
March 1984

- Analysis of Wisconsin's second surgical opinion program

- Additional information and/or copies may be obtained from:

  Tim Tyson
  Division of Policy and Budget
  Wisconsin Department of Health
  and Social Services
  P.O. Box 7850
  Madison, WI 53707
  (608) 266-9336

V. QUALITY CONTROL AND CORRECTIVE ACTION

North Carolina

"Medicaid Corrective Action Record Review"

- Document is intended to assist individual counties in identifying their specific problems in the area of Medicaid eligibility for the purpose of keeping Title XIX error rates within accepted Federal limits. County cases are reviewed to detect errors and suggestions are made as to how future errors can be avoided.

- NOTE: A newsletter is also published after each review and is shared with all counties. It identifies: errors, why they were made and what corrective action can be taken to resolve them.

- Additional information and/or copies may be obtained from:

  Linda Connelly
  North Carolina Division of
  Medical Assistance
  410 North Boylan Avenue
  Raleigh, NC 27603
  (919) 733-3590

VI. TPL AND RECOVERY

Delaware

"Medicare Recoveries"
(No final reports as yet - contract in effect until 7/1/85
Copies of Preliminary Proposal available)

- State contracted with consultant to act as a conduit with the fiscal intermediary to identify, through computer matching, crossover claims where Medicare recovery is appropriate and to establish a repayment schedule.

- Additional information and/or copies may be obtained from:

  David Michalik
  Delaware Medical Assistance Program
  P.O. Box 906, Biggs Building
  New Castle, DE 19720
  (302) 421-6133

Wisconsin

"The Wisconsin Child Support Guidelines: An Evaluation of Their Uses and Impact"
1984

"Study of Management and Operations of Child Support Agencies"
December 1984

- Reports on the medical support liability of absent parents

- Additional information and/or copies may be obtained from:

  Tim Tyson
  Division of Policy and Budget
  Wisconsin Department of Health
  and Social Services
  P.O. Box 7850
  Madison, WI 53707
  (608) 266-9336

VII. ELIGIBILITY AND COVERAGE

A. General

District of Columbia

"Analysis of District of Columbia Medicaid Eligibility Data"
December 1984

- o Eligibility data by assistance category.
- o Additional information and/or copies may be obtained from:

  Francine Towns
  Special Assistant
  Department of Human Services
  1331 H Street, N.W., Room 500
  Washington, DC 20005
  (202) 727-9693
  or
  Pracon, Incorporated
  10390 Democracy Lane
  Fairfax, VA 22030
  (703) 691-0762

B. Organ Transplants

Iowa

"Final Report of the Governor's Advisory Committee on Organ Transplants"
December 1984

- o Results of the committee's research and analysis of the medical, technical, ethical, political and financial issues surrounding organ transplants, as well as recommendations as to what role Iowa's Medicaid program should play in funding transplants.
- o Additional information and/or copies may be obtained from:

  Coleen Tompkins
  Bureau of Plan Development
  Iowa Department of Human Resources
  Hoover State Office Building
  Des Moines, IA 50319
  (515) 281-4187

C. EPSDT

New Jersey

"Clown Project"
November 1980

- Describes the "Clown Project", a "live" or film program of recipient education for the EPSDT program.

- Additional information and/or copies may be obtained from:

  Ruth Stekert, M.D. or
  Marion Newhart, R.N.
  Division of Medical Assistance
  and Health Services
  CN712
  Trenton, NJ 08625
  (609) 292-8197

New Jersey

"Asbury Park EPSDT School Health Demonstration"
November 1980

- Additional information and/or copies may be obtained from:

  Ruth Stekert, M.D. or
  Marion Newhart, R.N.
  Division of Medical Assistance
  and Health Services
  CN 712
  Trenton, NJ 08625
  (609) 292-8197

VIII. MEDICALLY INDIGENT AND UNCOMPENSATED CARE

Arkansas

"Report of the Arkansas Governor's Task Force on Indigent Health Care"
November 1984

- Report presents an overview of issues states face when dealing with the problem of health care for the indigent. Presents statistics, identifies the role of Medicaid, Medicare, ERISA and private insurance and offers an overview of various health policy directions. Recommendations focus on the following areas: expansion of Medicaid; development of a regionalized system of maternity care and care for children under 5; provider reimbursement; and private health insurance options and expansions.

- Additional information and/or copies may be obtained from:

  Lynn Cooper
  Arkansas Department of Human Services
  P.O. Box 1437
  Little Rock, AR 72203
  (501) 371-1001

California

"Health Insurance Options for the Uninsured/Underinsured"
1983

- Background for analyzing various alternative measures for increasing the extent of private health insurance coverage.

- Additional information and/or copies may be obtained from:

  Office of Planning and Review
  Department of Health Services
  714 P Street, Room 1392
  Sacramento, CA 95814

Colorado

"Colorado's Sick and Uninsured: We Can Do Better - Report of the Colorado Task Force on the Medically Indigent"
Volume 1
January 1984

- This report presents findings about the size, characteristics and needs of the medically indigent population, the problems with current approaches to care for the medically indigent, and recommended policy solutions. The Task Force proposes a combination of public and private initiatives: modest expansion of Medicaid, employment-based health insurance, a basic level of charity care by providers and cost sharing by consumers.

"Colorado's Sick and Uninsured: Colorado Health Survey"
Volume 2
January 1984

- The Colorado Health Survey (CHS) is the first major statewide Health survey of the medically indigent in Colorado. The CHS was requested to provide information previously unavailable about the medically indigent in terms of demographic characteristics, health status, health services, health expenditures and insurance coverage. The overall goal of the survey was to describe these specific characteristics of the poor and near-poor with special interest in regional variations.

"Colorado's Sick and Uninsured: Background Resource Papers"
Volume 3
January 1984

- This volume contains the research papers prepared by the staff for the Task Force to answer the following questions: who are Colorado's medically indigent; what are their health care needs and utilization patterns; who provides health care to them; and what options exist to finance their health care.

- Additional information and/or copies may be obtained from:

The Piton Foundation
511 16th Street, Suite 700
Denver, CO 80202
(303) 825-6246

Tennessee

"An Analysis of Health Care Options in Tennessee: Uncompensated Care"
January 1, 1985

- Report on the study of uncompensated care in Tennessee including the areas of: access to care by the uninsured; characteristics of recipients of uncompensated care; magnitude of such care provided; providers of uncompensated care; and policy options for uncompensated care issues.

- NOTE: the Executive Summary of this large report is contained in the Tennessee publication, "A Plan for Tennessee Health Care Cost Containment" (See entry in section VIII following)

- Additional information and/or copies may be obtained from:

  Sue Ellen Martin
  Division of Policy, Planning
  and Development
  Tennessee Department of Human
  Resources
  729 Church Street
  Nashville, TN 37219
  (615) 741-0213

Texas

"Task Force on Indigent Health Care: Final Report"
December 1984

- Governor's Task Force recommendations to address the issue of indigent health care in Texas, specifically focusing on: scope of services, eligibility criteria, administrative structure and methods of finance.

- Additional information and/or copies may be obtained from:

  Bryan Sperry
  Task Force on Indigent Health Care
  P.O. Box 12068, Capitol Station
  Austin, TX 78711

Wisconsin

"Wisconsin Uninsured: The Scope of the Problem and Alternative Solutions"
December 24, 1984

"Reports on Model Health Insurance Plans for the Uninsured and Long Term Care Insurance"
February 5, 1985

- A model health insurance plan for the uninsured and a report on the feasibility and advisability of promoting the inclusion of long term care coverage in private insurance plans. (Both reports required by, and submitted to the Wisconsin Legislature)

- Additional information and/or copies may be obtained from:

  Peggy Usitalo
  Bureau of Health Care Financing
  Division of Health
  Wisconsin Department of Health
  and Social Services
  1 West Wilson Street, Room 244
  P.O. Box 309
  Madison, WI 53707
  (608) 267-9474

IX. COST CONTAINMENT

California

"Inventory of Medi-Cal Cost Containment Measures (1975-1983)"
1983

- Proposals for cutting Medicaid costs.
- Additional information and/or copies may be obtained from:

  Office of Planning and Review
  Department of Health Services
  714 P Street, Room 1392
  Sacramento, CA 95814

Connecticut

"Medicaid Management in an Era of Scarce Resources"
February 1984

- Study of cost containment alternatives in Connecticut's Medicaid program in the following areas: long-term care, inpatient hospital costs, hospital outpatient and community medical services, and administration and program management.
- Additional information and/or copies may be obtained from:

  Department of Income Maintenance
  110 Bartholomew Avenue
  Public Information Office
  Hartford, CT 06106
  (203) 566-4978

Kansas

"Special Analysis: Alternatives for Cost Containment in the Kansas Medical Assistance Program"
February 1982

- The report is intended to serve as a useful reference for evaluating alternatives by providing a comprehensive framework for understanding the Kansas program's objectives, requirements and operation. Describes what the program benefits are, who is eligible to receive them, how reimbursement works, what the federal government requires, what is left to the state to decide, who is benefiting and how much, what other states are doing, and what Kansas has done.

- Additional information and/or copies may be obtained from:

  Kathryn Klassen
  Director, Medical Services Division
  Department of Social and Rehabilitation Services
  State Office Building
  Topeka, KS 66612
  (913) 296-3981

Michigan

"Michigan Medicaid Task Force Report: Containing Medicaid Costs"
1984

- The Task Force, in order to find ways to limit cost increases without impairing access for recipients, was mandated to:

  - evaluate the costs, benefit structures, utilization control and reimbursement policies of Michigan Medicaid;
  - identify areas in which policy or program structures may be modified;
  - develop recommendations to achieve cost containment goals.

  Proposed 55 recommendations in areas such as alternative delivery systems, reducing inpatient utilzation and changes in service coverage.

- Additional information and/or copies may be obtained from:

  Vernon Smith
  Medical Services Administration
  Michigan Departmen of Social Services
  P.O. Box 30037
  Lansing, MI 48910
  (517) 373-9440

Minnesota

"Minnesota Health Care Markets: Cost Containment and Other Public Policy Goals"
Prepared for the Minnesota Legislature by the Minnesota Department of Health
January 15, 1985

- The report was written in response to a mandate from the 1984 Minnesota Legislature to consider regulatory proposals and competitive initiatives and to develop recommendations for an integrated comprehensive cost containment program for acute care health services. Contains an analysis of the health care cost problem and the acute health care marketplace and recommendations for the legislature, government, employers, insurers and providers.

- Additional information and/or copies may be obtained from:

  Marianne Miller
  Health Economics Program
  Minnesota Department of Health
  717 Delaware Street, S.E.
  P.O. Box 9441
  Minneapolis, MN 55440
  (612) 623-5184

Minnesota

"Health Care Cost Containment: Issue Team Report"
October 1984

- Report of the Executive Issues Team including the development of recommendations dealing with reducing rising Medicaid expenditures.

- Additional information and/or copies may be obtained from:

  John Dilley, Director
  State Health Planning and
  Development Agency
  200 Capitol Square Building
  550 Cedar Street
  St. Paul, MN 55101
  (612) 296-2407

Missouri

"Health Care Cost Containment in Missouri"
Department of Social Services
February 1984

- Describes the record of cost containment actions taken in Missouri in recent years representing a comprehensive but incremental approach to the issue of rising costs. The Missouri experience has been successful in that health care increases in state-operated programs have been held to 5% or less per year over a three year period.

- Additional information and/or copies may be obtained from:

  Ron Meyer, Manager
  Policy Planning and Evaluation
  Department of Social Services
  Division of Medical Services
  308 East High Street
  P.O. Box 88
  Jefferson City, MO 65103
  (314) 751-3277

Missouri

"Governor's Task Force on Health Care Costs: Final Report"
December 13, 1984

- Recommendations aimed at containing Medicaid costs in Missouri, specifically focusing on: health care financing, control of health system capacity and data on utilization of services.

- Additional information and/or copies may be obtained from:

  Tammy Babcock
  Department of Social Services
  Division of Medical Services
  308 East High St., P.O. Box 88
  Jefferson City, MO 65103
  (314) 751-3277

Nebraska

"Medicaid Task Force Report"
Nebraska Department of Social Services
November 15, 1983 (Original Report)
December 1984 (Second Report)

- Task Force was charged with scrutinizing all areas of the Medicaid program to identify available opportunities to curtail the growth of the Medicaid program. The initial report found that adequate cost containment measures would not be achieved using the existing overall methodology for the Nebraska Medicaid program and that innovative approaches and a willingness to experiment was necessary. The second report tracks the progress that has been made over the previous year and identifies new priorities.

- Additional information and/or copies may be obtained from:

  Melvin Clothier
  Assistant Administrator
  Medical Services Division
  Nebraska Department of Social Services
  P.O. Box 95026
  301 Centennial Mall South, 5th Floor
  Lincoln, NE 68509
  (402) 471-3121

Ohio

"Governor's Commission on Ohio Health Care Costs"
July 9, 1984

- Study to develop, review and recommend proposals to contain health care costs including strategies to: improve the cost-effectiveness of state and private sector programs; ensure the availability of data to assist policymakers; reduce excess capacity and increase the availability of services in medically underserved areas; redistribute the cost of uncompensated care; and promote physical and mental well-being.

- Additional information and/or copies may be obtained from:

  Kathryn Glynn
  Assistant Deputy Director
  Medicaid Administration
  Ohio Department of Human Services
  30 East Broad Street - 31st Floor
  Columbus, OH 43215
  (614) 466-3196

Oregon

"Staff Report on the Recommendations of the House Task Force on Health Care Cost Containment"
December 1984

- Report on recommendations for cost containment in Oregon including: information about health care costs nationally and in Oregon; strategies recommended to control costs and legislative measures supported by the Task Force.

- Additional information and/or copies may be obtained from:

  Bruce Bishop
  Administrator of the Task Force
  (503) 378-5783

Pennsylvania

"Medical Assistance Cost Containment"
March 1984

- Describes a range of Medical Assistance cost containment proposals for FY 85, recently implemented cost containment measures and measures considered but not implemented.

- Additional information and/or copies may be obtained from:

  Gerald Radke
  Deputy Secretary for Medical Assistance
  Pennsylvania Department of Public Welfare
  Health and Welfare Building - Room 515
  7th and Forster Streets
  Harrisburg, PA 17120
  (717) 787-1870

Tennessee

"A Plan for Tennessee Health Care Cost Containment"
January 1985

- Report of the Select Committee on Health Care Cost Containment regarding: legislative and administrative strategies recommended to slow the rate of increase in the cost of health care services; review of strategies to foster a competitive health care system; control of utilization; promotion of health and wellness; and model cost conscious behaviors in the public sector.

- Additional information and/or copies may be obtained from:

  Sue Ellen Martin
  Division of Policy, Planning
  and Development
  Tennessee Department of Human Resources
  729 Church Street
  Nashville, TN 37219
  (615) 741-0213

X. LONG TERM CARE

Florida

"Long-Term Care Study"
1984

- o A study to assess the needs of Florida's elderly and determine service system improvements.

- o Additional information and/or copies may be obtained from:

  Skip Martin
  Medicaid Cost Reimbursement
  1317 Winewood Boulevard
  Tallahassee, FL 32301
  (904) 488-9350

Iowa

"A Review of the Feasibility and Cost of Establishing a Special Class of Intermediate Care Facilities Designed to Serve Brain Injured Persons or Other Persons with Special Disabilities"
January 1, 1985

- o Additional information and/or copies may be obtained from:

  Gary Gesaman
  Manager
  Long Term Care Section
  Bureau of Medical Services
  Iowa Department of Human Services
  Hoover State Office Building
  Des Moines, IA 50319
  (515) 281-5586

Maryland

"Maryland Appraisal of Patient Progress"
1982

- o A patient care management system instruction manual aimed at improving patient care in long-term care facilities by frequent interdisciplinary assessments of the patient's progress under a specific treatment plan.

- o Additional information and/or copies may be obtained from:

  Division of Licensing and Certification
  Department of Health and Mental Hygiene
  201 West Preston Street
  Baltimore, MD 21201

Texas

"A Statistical Investigation of the Relationship Between Facility Case Mix and Expenditures in Texas Nursing Homes: Report of Findings"
1984

- Additional information and/or copies may be obtained from:

  Robert Conkright
  Texas Department of Human Resources
  P.O. Box 2960
  Austin, TX 78769
  (512) 450-4046

XI. PROGRAM INTEGRITY

Pennsylvania

"Fraud and Abuse Enforcement Activities"
February 1985

- Pennsylvania's approach to fraud and abuse control.

- Additional information and/or copies may be obtained from:

  Suzanne Hansen
  Project Manager
  Medicaid Information and
  Assistance Project
  American Public Welfare Association
  1125 15th Street N.W., Suite 300
  Washington, DC 20005
  (202) 293-7550

XII. GENERAL INFORMATION AND CHARACTERISTICS OF STATE MEDICAID PROGRAMS

Alabama

"Alabama Medicaid Annual Report"
(Published annually in May of each year)

- o General information regarding the Alabama Medicaid program including tables, maps and narrative

- o Additional information and/or copies available from:

  Alabama Medicaid Agency
  2500 Fairlane Drive
  Montgomery, AL 36130
  (205) 277-2710

North Carolina

"Medicaid in North Carolina: Annual Report for 1983-1984"
(Report for 1984-1985 will be available in mid-Fall 1985)

- o Report gives information on the North Carolina Medicaid program including expenditures, number of eligibles, services offered, etc.

- o Additional information and/or copies may be obtained from:

  Patsy Slaughter
  North Carolina Division of
  Medical Assistance
  410 North Boylan Avenue
  Raleigh, NC 27603
  (919) 733-6964

XIII. OTHER

Alabama

"Preventive Health Strategies for Medicaid and Other State Agencies"
June 1985

- Recommendations of Preventive Health Task Force.
- Additional information and/or copies available from:

  Alabama Medicaid Agency
  2500 Fairlane Drive
  Montgomery, AL 36130
  (205) 277-2710

New Jersey

"Preventive Health Outreach: Hudson County"
March 1985

- Additional information and/or copies may be obtained from:

  Ruth Stekert, M.D.
  or
  Marion Newhart, R.N.
  Division of Medical Assistance
  and Health Services
  CN 712
  Trenton, NJ 08625
  (609) 292-8197

INDEX OF WRITTEN MATERIAL ON MEDICAID

TABLE OF CONTENTS

I. COST CONTAINMENT

1. **Hospital Cost Containment: A Legislator's Guide**
Yondorf, Barbara; Shanks, Nancy H.; and Pierce, Robert. National Conference of State Legislatures, May, 1985.

This guide, developed by a group of legislators and legislative staff from 25 states, concentrates on the primary roles states can play in dealing with hospital cost containment.

2. **State Efforts at Health Care Cost Containment**
Hekman, Ellen. National Conference of State Legislators (NCSL), September, 1984.

This report includes 23 tables that indicate which states are using each of 64 major programs for containing health care costs. The information is based on a survey conducted by NSCL in December 1983 and updated in July 1984.

3. **Harnessing State Expertise to Contain Health Care Costs: The Potential of Employee Health Benefits, Medicaid and Health Planning Programs**
National Governors' Association, February 1984.

This report identifies state program policies in the areas of Medicaid, state employee health benefits and health planning which can serve as models for other states in their cost containment efforts.

4. **Developing State Policy on Health Care Costs: Governors' Task Force Initiatives**
Wicks, Elliot, Ph.D., with Luehrs, John. National Governors' Association, February, 1984.

This document shares information about the purposes, organization, and findings and recommendations of task forces and special commissions established by governors to address the problem of containing health care costs.

5. **Managing Health Care Costs: Private Sector Innovations**
Sullivan, Sean, with Ehrenhaft, Polly M. Amercian Enterprise Institute, 1984.

This book presents four case studies exemplifying private sector efforts toward health care cost containment. Following these case studies is an edited transcript, in panel discussion format, of a 1983 conference sponsored by AEI's Center for Health Policy. The focus of the discussion is developing new models of cost containment and shifting costs from the public to the private sector.

6. **Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions**
American Enterprise Institute, 1983.

This book examines the potential of a new approach to controlling health care costs that features market reforms based on incentives. The book is organized into 4 major sections: (1) develops a conceptual framework for assessing the potential of incentives-based reforms in the financing and delivery of health care; (2) traces new areas in the effort to contain costs; (3) and (4) examine specific federal policies in fiscal and administrative issues and the areas of regulation and litigation.

7. **A Primer on Competitive Strategies for Containing Health Care Costs**
U.S. General Accounting Office (GAO), 1982.

Pursuant to a congressional request, GAO analyzed the procompetition strategies for health care cost containment, focusing on a description of their major features, their underlying assumptions, and the bases upon which their impact on health care costs have been estimated. Two major procompetitive approaches, cost-sharing and the alternative delivery system, are highlighted.

8. **Cost Containment and Changing Physicians' Practice Behavior: Can the Fox Learn to Guard the Chicken Coop?**
Eisenberg, John M., and Williams, Sankey V. Journal of the American Medical Association 246 (November 13, 1981) 2196-2201.

This article reviews six different strategies which have been used to increase physician awareness of health care costs and efforts to reduce medical expenditures.

9. **State Guide to Medicaid Cost Containment**
Spitz, Bruce. Intergovernemntal Health Policy Project and the National Governors' Association, September, 1981.

This guide identifies a variety of viable cost containment options which are capable of minimizing harmful effects on recipients and institutions and, at the same time, offer the greatest potential for holding down the rate of growth in program expenditures.

II. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

1. **Study of Selected Outcomes of the Early and Periodic Screening, Diagnosis, and Treatment Program in Michigan**
   Keller, William, Ph.D. Public Health Reports 98 (March-April 1983) 110-119.

   The purpose of this study was to provide a better understanding of whether the EPSDT program in Michigan is improving the health status of its participants, and at what cost. Generally, the results showed EPSDT participation to be associated with desirable outcomes of health status and costs.

2. **A Guide to the Design, Development, and Implementation of an EPSDT Subsystem of the MMIS**
   Hamlin, David, and Stella, Linda. Alexander Grant Information Systems, San Francisco, California, March 1982.

   This feasibility study was developed for HCFA to design and plan for the implementation of an EPSDT case management and data collection system. Includes information regarding alternatives considered, the design of the recommended system and a cost-benefit analysis of each alternative.

3. **EPSDT: Effective Practices: State Developed Technology**
   Child Health Staff, Office of Standards and Performance Evaluation, Bureau of Program Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, August, 1982.

   EPSDT best practices are identified by a review of literature, a telephone survey of HCFA Regional Office EPSDT coordinators, site visits to selected states and discussions at the 1981 National EPSDT Conference.

4. **Proceedings: 1981 National EPSDT Conference**
Child Health Staff, Office of Standards and Performance Evaluation, Bureau of Program Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, August, 1982.

Includes presentations on a wide range of issues discussed at the 1981 National EPSDT conference held on March 17-18, 1981.

5. **EPSDT: Marketing Resource Manual for EPSDT Provider Recruitment**
Child Health Staff, Office of Standards and Performance Evaluation, Bureau of Program Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, June, 1982.

This volume was prepared to assist states in developing marketing approaches to ensure provider participation in the EPSDT program. (Based on materials developed by Community Health Foundation).

IIIA. ELIGIBILITY

1. **Adopting a Medically Needy Program**
Wulsin, Lucien. Clearinghouse Review, National Health Law Program, December, 1984.

This article presents an overview of issues related to the medically needy, including the demography of the medically needy, benefits and problems associated with medically needy programs, and a discussion of the major issues which arise when adopting a medically needy program.

2. **New York Requires Employed Medicaid Recipients to Enroll in Employer-Sponsored Health Insurance**
U.S. General Accounting Office (GAO), August 10, 1984.

As part of its review of the use of recipient health insurance coverage to avoid Medicaid costs, GAO reported on the New York State practice of requiring working recipients to enroll in available employer-sponsored health insurance plans.

IIIB. SERVICE COVERAGE

1. **Medicaid Coverage and Payment Policies for Organ Transplants: A Fifty State Review**
King, Kathleen; Reese, Douglas; and Zachary, Sandy. Intergovernmental Health Policy Project (IHPP) and the Health Care Financing Administration (HCFA), July, 1985.

This report contains the findings of a survey conducted by IHPP, in conjunction with HCFA, regarding the 50 states' Medicaid policies on organ transplantation. It includes topics such as coverage of transplants, costs, Medicaid payment methods and transplant criteria.

2. **Mental Health Benefits Under Medicaid: A Survey of the States**
Toff, Gail. Intergovernmental Health Policy Project, January, 1984.

The purpose of this study was to collect information regarding the current status of each state's mental health benefits under Medicaid via surveys with the states and a review of state plan information.

IV. FRAUD AND ABUSE/PROGRAM INTEGRITY

1. **Report of a Study Under the Auspices of President's Council on Integrity and Efficiency: Using the Computer Against Fraud and Abuse in Medicare and Medicaid**
Office of Inspector General, U.S. Department of Health and Human Services, May, 1985.

This report summarizes federal, state, and private health-related organizations' responses to a nationwide survey regarding health care program vulnerabilities to fraud and abuse. The survey assessment: (1) addresses the major vulnerability areas found in the detection and prevention of health care fraud and abuse; (2) documents the significant accomplishments of the responding entities in these areas; and (3) assesses, by organizational category, the future needs in efforts to curtail fraudulent and abusive activities in the health care sector.

2. **Prescription Drug Abuse and Diversion in the Medicaid Program**
Office of Inspector General, Department of Health and Human Services, October 1983.

This report to the Inspector General on prescription drug abuse and diversion presents the results of studies conducted by the Office of Program Inspections and the Office of Audit in ambulatory programs in 5 jurisdictions. Included is an analysis of the extent and cost of fraud/abuse, current federal and state efforts in this area and effective control mechanisms.

V. GENERAL PROGRAM INFORMATION

1. **Health Care Financing Program Statistics: Analysis of State Medicaid Program Characteristics, 1984**
Office of the Actuary, Health Care Financing Administration, U.S. Department of Health and Human Services, August, 1985.

This report, reflecting HCFA's efforts to design and implement a data system which unifies selected state Medicaid program charactersitics into a single source, presents data on program characteristics as of March 31, 1984. Included are the following types of information on a state-by-state basis: eligibility and reimbursement policies; service and coverage limitations; administrative, finance, demographic, economic and medical sector characteristics and state-only programs.

2. **Need for Legislative Change Affecting the Medicaid Program**
U.S. General Accounting Office (GAO), November 30, 1984.

GAO has been conducting an ongoing review of the Medicaid program and found that a possible inequity could result in states having to pay full medical costs for certain Medicaid recipients covered under self-insured health plans regulated by the Employee Retirement Income Security Act (ERISA). Since ERISA is federally regulated, insurance plans under ERISA may designate themselves as secondary payors and thus states are placed in the position of assuming the costs of medical care for these recipients through Medicaid.

3. **Short-Term Evaluation of Medicaid: Selected Issues**
Health Care Financing Administration Grants and Contracts Report, October 1984.

This report synthesizes recent research findings on the trends and program changes in Medicaid, as well as new findings in the areas of eligibility, institutionalized recipients, and dual enrollees for Medicaid and Medicare.

4. **HCFA Statistics**
Bureau of Data Management and Strategy, Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services, September 1984.

This booklet provides data detailing the growth in health care costs and in HCFA programs. Statistics are classified into six broad categories: populations, providers/suppliers, expenditures, utilization, administrative, and fraud and abuse/quality control.

5. **Medicaid: Legislative History, Program Description, and Major Issues**
O'Sullivan, Jennifer. Congressional Research Service, The Library of Congress, July 24, 1984.

This report provides an overview of Medicaid including a legislative history, description of program requirements, a discussion of major issues, and key program statistics.

6. **The 1981 Omnibus Reconciliation Act and Medicaid Spending**
Holahan, John. Urban Institute, May 1984.

This paper analyzes changes in the structure of Medicaid that occurred in 1982 following passage of the Omnibus Budget Reconciliation Act (OBRA). It presents comparative data on program expenditures for the pre-OBRA and post-OBRA periods and attempts to understand how states achieved cutbacks resulting from OBRA.

7. **Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses**
U.S. General Accounting Office (GAO), May 1, 1984.

GAO obtained information on health care practitioners in three states who had their licenses revoked or suspended to determine whether they were relocating and continuing to treat patients under the Medicaid and Medicare program in other states.

8. **Information Regarding the Effect of Applying the Representative Tax System to the General Revenue Sharing, Medicaid, and Vocational Education Programs**
U.S. General Accounting Office (GAO), September 9, 1983.

In response to a congressional request, GAO analyzed the effect that the Representative Tax System (RTS) would probably have on federal aid to states if it were used in three formula-based programs: (1) Revenue Sharing; (2) Medicaid; and (3) Vocational Education.

9. **Changing Medicaid Formula Can Improve Distribution of Funds to States**
U.S. General Accounting Office (GAO), March 9, 1983

In response to an Omnibus Budget Reconcilation Act of 1981 mandate, GAO evaluated the Medicaid formula relative to narrowing differences between program benefits provided by states, providing a more equitable distribution of tax burdens between richer and poorer states, and reducing the rate of increase in federal Medicaid spending.

10. **Restructuring Medicaid: An Agenda for Change - Summary Report and Background Papers**
National Study Group on State Medicaid Strategies, Center for the Study of Social Policy, Washington, D.C., January, 1983.

The National Study Group on State Medicaid Strategies was formed in 1982 to explore alternative directions to the provision of supported health care for the poor. The background papers were prepared to assist the Study Group as they developed their recommendations for a fundamental restructuring of the Medicaid program. The summary report summarizes the Group's conclusions and recommends a fundamental restructuring of the existing federal-state Medicaid program.

11. **Health Care Financing Program Statistics: The Medicare and Medicaid Data Book, 1981.**

and

Heath Care Financing Program Statistics: The Medicare and Medicaid Data Book, 1983.
Office of Research and Demonstrations, Health Care Financing Administration, U.S. Department of Health and Human Services.

These two reports present basic statistics and analyses of the Medicare and Medicaid programs. Narrative descriptions, tables, and graphs offer data related to eligibility, benefits, financing, administration, enrollments and recipients, expenditures, trends for selected services, and information systems.

12. **Evaluation Options for Medicaid**
Office of Research and Demonstrations; Health Care Financing Administration, U.S. Department of Health and Human Services, November 1982.

This report, which draws heavily on a series of interviews with individuals knowledgeable about and involved in Medicaid decision-making at the state and national level, represents an initial step in the development of an evaluation plan for the Medicaid program. Study objectives include: (1) identify key issues in Medicaid; (2) assessing the utility of HCFA data bases in addressing these assess; and (3) recommending an evaluation strategy for Medicaid.

13. **Uses, Strengths, and Weaknesses of Selected Medicaid Data Bases**
Cromwell, Jerry, and Schurman, Rachel. Health Economics Research, Inc.; and Adler, Gerald. Divison of Beneficiary Studies, Office of Research and Demonstrations, Health Care Financing Administration, U.S. Department of Health and Human Services, March, 1982.

Because of the complexity of the Medicaid program, adequate sources of data for assessing various state alternatives have been lacking. In this report, a number of data bases developed and refined by the HCFA Office of Research and Demonstrations (ORD) are summarized. The strengths and weaknesses of each information source are discussed based upon a synthesis of views expressed at an ORD conference held in August, 1981.

14. **Medicaid in the Reagan Era: Federal Policy and State Choices**
Bovbjerg, Randall, and Holahon, John. The Urban Institute, 1982.

This report assesses the Reagan administration's Medicaid policies, the changes Congress made in the law in 1981, and the states' responses. The report focuses on causes of spending and on cost containment.

VI. LONG-TERM CARE

A. General

1. **Financing and Delivery of Long-Term Care Services for the Elderly**
O'Shaughnessy, Carol; Price, Richard; and Griffith, Jeanne. Congressional Research Service, The Library of Congress, Washington, D.C., October 17, 1985.

This report provides an overview of selected policy issues on long-term care financing, including information on characteristics of the elderly and their need for and utilization of long-term care services, and a review of public sector programs and private sector approaches to financing long-term care services.

2. **An Overview of Long-Term Care**
Doty, Pamela; Lui, Korbin; and Wiener, Joshua. Health Care Financing Review 6 (Spring 1985) 69-78.

This article offers background information and statistics relevant to long-term care: demographics, needs assessment, sources of long-term care, supply and expenditures. Also, government programs for financing long-term care are reviewed, followed by a brief discussion of quality of care issues and options for financing reform.

3. **Channeling Effects for an Early Sample at 6-Month Follow-up**
Mathematica Policy Research, Inc., Princeton, New Jersey, May, 1985 (revised).

The Channeling demonstration project is intended to test whether a carefully managed approach to the provision of community-based long-term care could help control overall long-term care costs while maintaining or improving the well-being of its elderly clients. This report provides an initial analysis of the effects of Channeling on hospitalization, nursing home use, mortality, formal and informal service use, client functioning and well-being, transfer payments and housing expenses.

4. **Summary Report: Workshop on Federal Medicaid Oversight**
National Association of State Mental Retardation Program Directors (NASMRPD), Alexandria, Virginia, April 4, 1985.

The primary aim of this report is to summarize briefly the issues discussed at a special two-day workshop on Federal Medicaid Oversight Activities sponsored by NASMRPD on March 25-26, 1985.

5. **Federal Administrative Constraints on State Medicaid Outlays for MR/DD Recipients**
National Association of State Mental Retardation Program Directors (NASMRPD), Alexandria, Virginia, April, 1985.

In October, 1984, NASMRPD conducted a nationwide survey of state MR/DD agencies to identify federal policies and practices that were impairing the states' capability for improving services for Medicaid-eligible MR/DD recipients. The results of the survey and an analysis of the findings are summarized in this report.

6. **Adult Residential Day Care: A Program Development and Operations Guide**
Mountain States Health Corporation, October 1984.

Presents a program development and operations guide for adult residential day care, including recruitment and selection of providers, day care provider training, recruitment and assessment of participants, care plan contracts, follow-up, provider support and quality control, program development and administration.

7. **Managing Programs for the Elderly: Design of a Social Information System**
Birnbaum, Howard; Burke, Robert; and Pratter, Frederick. Health Care Financing Review 5 (Winter 1983) 11-23.

This paper describes a comprehensive approach to assembling a health care information system to monitor programs for the elderly and disabled in a cost effective manner.

8. **Care for the Chronically Ill: Nursing Home Incentive Payment Experiment**
Weissert, William, et al. Health Care Financing Review, 5 (Winter 1983) 41-49.

According to this article, nursing home reimbursement systems which do not adjust payment levels to patient care needs lead to access problems for heavy-care patients. Described is a nursing home reimbursement system which is intended to simultaneously mitigate problems of restricted access, inefficient use of beds, and nonoptimal care.

9. **Conference Proceedings: Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives**
Health Care Financing Administration, U.S. Department of Health and Human Services, January 1984.

Papers prepared for this conference address issues in developing and implementing long-term care programs. Topics include long-term care insurance, life care communities, home equity conversion, social/health maintenance organizations, state and federal tax modifications, housing, family care and volunteerism.

10. **The Long-Term Care Marketplace: An Overview**
Scanlon, William J. and Feder, Judith. The Urban Institute, November, 1983 (revised).

This article provides an overview of the long-term care marketplace -- identifying the long-term care population, examining how population and policy changes have affected the use and nature of long-term care services, and exploring how future population and socioeconomic changes are likely to influence the long-term care market.

11. **Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly**
U.S. General Accounting Office (GAO), Report to the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, October 1983.

In response to a congressional request, GAO assessed Medicaid's nursing home services nationwide to provide information on the characteristics of nursing home residents, program expenditures, nursing home bed supply, and Medicaid reimbursement policies.

12. **Federal Funding of Long-Term Care for the Elderly**
U.S. General Accounting Office (GAO), June 15, 1983.

In response to a congressional request, GAO reported on the amount of federal funds that are being spent on long-term care for the elderly under various programs and the amount being spent for back-up days of care in acute care hospitals when a lower level of care is needed but unavailable.

13. **Public Programs Financing Long-Term Care**
Cohen, Joel. The Urban Institute, January, 1983 (revised).

This paper describes the main public programs that support long-term care: Medicaid, Medicare, social and nutrition service programs authorized by the Older Americans Act, Supplemental Security Income, Title XX, long-term care programs operated by the Veterans Administration, and various housing programs which have been used to assist the elderly and disabled. For each program, expenditures and, where possible, utilization are reported for each state.

14. **A Health Maintenance Organization Design for Long-Term Care Under Medicaid**
Hogan, Andrew J. Socio-Economic Planning Sciences, 16 (1982) 279-292.

The paper suggests how the needs of chronically ill or disabled persons receiving medical assistance under Medicaid can be met within the framework of a health maintenance organization (HMO).

15. **Nursing Home Pre-Admission Screening: A Review of State Programs**
Knowlton, Jackson; Clauser, Stephen; and Fatula, James. Health Care Financing Review, 3 (Winter 1982) 75-87.

From January through March of 1981, the Health Care Financing Administration conducted a survey to determine if agencies administering the Medicaid program had a nursing home preadmission screening program for Medicaid recipients. This article presents the findings of the survey and explores several aspects of the Medicaid program influencing the effectiveness of preadmission screening.

16. **Current and Future Developments of Intermediate Care Facilities for the Mentally Retarded: An Update**
Toff, Gail E. Intergovernmental Health Policy Project (IHPP), 1982.

An update to an ICF/MR survey originally conducted by IHPP and Human Services Research Institute in 1980 which identifies trends including the significance of section 2176 waivers as a funding source for the development of programs for the mentally retarded and developmentally disabled and the slow growth in ICF/MR programs.

B. Home and Community-Based Care Waivers (2176)

1. **Medicaid "2176" Waivers for Home- and Community-Based Care**
O'Shaughnessy, Carol and Price, Richard. Congressional Research Service, The Library of Congress, June 21, 1985.

This report presents background on the section 2176 home- and community-based waiver program, including legislative history, a summary of implementing regulations, an overview of types of waivers granted, and case examples of waivers.

2. **Report to Congress: Studies Evaluating Medicaid Home- and Community-Based Care Waivers**
Office of Research and Demonstrations, Health Care Financing Administration, Department of Health and Human Services, December, 1984.

This report describes the key features, implementation status and program impacts of the Medicaid Home- and Community-Based Care waiver

program as of December 31, 1984. Information available at the early stages of program implementation is presented and is based on studies which comprise the first year of the Department's three-year evaluation of the waiver program. These studies focus on: a) an account of the ways in which states have chosen to implement Section 2176 waiver programs; and b) a preliminary analysis of the cost consequences of the waivers based on the earliest expenditure reports. The second and third years of the study will yield quantitative evidence of program impacts.

3. **A Comparison of Medicaid Waiver Applications for Populations that are Mentally Retarded and Elderly/Disabled**
Lakin, K. Charlie, et al. Mental Retardation 22 (August 1984) 182-192.

This paper examines state responses to the Medicaid waiver provisions of P.L. 97-35 through a review of state waiver applications through February 15, 1983. Information is presented about the populations, services, and costs of the proposed mental retardation programs with direct comparison with proposed programs for people who are elderly/disabled.

4A. **Characteristics of Medicaid Home- and Community-Based Waiver Program Applications**

Volume I: Background and Summary
Krieger, Martha Jacoby; Weissert, William G.; and Cohen, Joel. The Urban Institute, December 9, 1982.

Volume I of this report provides background information on the enabling legislation and the application approval process. Also described is the schema by which waiver applications are summarized and the waivers requested.

4B. **Characteristics of Medicaid Home- and Community-Based Waiver Program Applications**

Volume II: Abstracts of State Waiver Applications
Kreiger, Martha Jacoby, and Potemken, Donna. The Urban Institute, December 9, 1982.

This volume presents abstracts of each state's waiver application(s).

VII. MEDICAID MANAGEMENT INFORMATION SYSTEMS

Information resources for this subject area are currently under development.

VIII. MEDICALLY INDIGENT/UNCOMPENSATED CARE

1. **Profiles of State Programs of Assistance to the Medically Indigent**
Desonia, Randy, and King, Kathy. Intergovernmental Health Policy Project, December, 1985.

   This report describes the various state and state/county health care programs that may be accessed by the medically indigent. The programs listed are funded within the state, usually by the state and/or county governments. Programs that have matching federal funds, such as Medicaid, are specifically excluded.

2. **Access to Care for the Medically Indigent: A Resource Document for State and Local Officials**
Academy for State and Local Government, Washington, D.C., Final Report - March 30, 1985.

   This report was developed to provide state and local officials with information on the nature and scope of the medically indigent issue, including: various legal approaches to financing of indigent health care; legislative and judicial trends; alternative legal structures to define obligations more clearly so as to avoid problems/litigation; and model state and local programs.

3. **A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent**
Luehrs, John, and Desonia, Randy. National Governors' Association and the Intergovernmental Health Policy Project, November 1984.

   This document, based on state survey responses, highlights the activities of special deliberative groups such as Task Forces and Commissions established by states to address the problem of health care for the medically indigent. Background information and policy options for state and local officials concerned with medically indigent issues are presented as well as: an overview of the size and nature of the population; problems of access to care; analysis of state laws and judicial decisions; and state by state information regarding who has legal responsibility for financing indigent health care.

(Programs included in the report are funded by state and/or county governments; the report does not include programs that have matching federal funds such as Medicaid).

4. **Health Care for the Uninsured**
Lewin, Marion Ein, and Lewin, Lawrence, Business and Health (September, 1984) 9-14.

This article, directed primarily toward employers, presents information on who the poor and uninsured are, how their care is being financed currently, and what options exist to fill gaps and redress inequities.

5. **Falling Through the Cracks: Poverty, Insurance Coverage and Hospitals' Care to Poor, 1980 and 1982**
Feder, Judith; Hadley, Jack; and Mullner, Ross. The Urban Institute, June 1984.

This paper demonstrates the legitimacy of concerns regarding the uninsured poor's access to health care, particularly hospital care. Information is presented on the growth in the need for free medical care; how hospitals have responded; and policies to ensure that the poor have access to health care services.

6. **Coverage of Uncompensated Care Under Prospective Hospital Reimbursement Systems**
National Health Law Program, May 11, 1984.

This report describes uncompensated care coverage under prospective hospital reimbursement systems in New Jersey, New York, Massachusetts, and Maryland, including strengths and weaknesses of existing reimbursement methods, and their effects on both the poor and hospitals.

IX. PREPAID AND CAPITATED HEALTH PLANS

1. **Medicaid and Capitated Competitive Contracting: The Arizona Experiment**
   Kirkman-Liff, Bradford; Williams, Frank G.; and Wilson II, L.A. New England Journal of Human Services 5 (Summer, 1985) 30-36.

   This article describes Arizona's experience with capitated competitive contracting for health services for Medicaid patients under its Arizona Health Care Cost Containment System (AHCCCS).

2. **Enrollment in and Disenrollment from Health Maintenance Organizations by Medicaid Recipients**
   DesHarnais, Susan I. Health Care Financing Review 6 (Spring 1985) 39-50.

   This article presents an analysis of utilization levels and physician contact patterns prior to HMO enrollment and following HMO disenrollment of Medicaid recipients in Wayne County, Michigan.

3. **Health Care Financing Grants and Contracts Report: Health Maintenance Organization Risk Contracting Under Medicare**
   Office of Research and Demonstrations, Health Care Financing Administration, U.S. Department of Health and Human Services, September, 1984.

   This report describes the operational aspects of health maintenance organizations (HMOs) and competitive medical plan risk-based contracting with the Medicare program including financial, marketing, health care delivery and contract administration issues.

4. **Demonstrations of Alternative Delivery Systems Under Medicare and Medicaid**
   Galblum, Trudi W., and Trieger, Sidney. Health Care Financing Review 3 (March 1982) 1-11.

   This article discusses findings from a number of Medicare and Medicaid demonstrations including information on plan participation, marketing, and reimbursement under alternative delivery systems.

5. **How Health Maintenance Organizations Control Costs**
U.S. General Accounting Office (GAO), October 29, 1981.

GAO evaluated health maintenance organizations' (HMOs) attempts to reduce health care costs. GAO analyzed the results of a questionnaire sent to members and former members of 12 HMOs concerning their satisfaction with health services, and compared the HMO premiums with those that a health insurance company would charge for the same benefits.

6. **HMOs: Issues and Alternatives for Medicare and Medicaid**
Trieger, Sidney; Galblum, Trudi W.; and Riley, Gerald. Office of Research, Demonstration and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services, 1981.

This paper presents an overview of the major issues and alternatives which need to be addressed in order to increase public payor participation in HMOs, including: legislative barriers to HMO enrollment, HMO benefits and liabilities, reimbursement problems and techniques, marketing strategies, quality assurance, administrative issues, and future needs for research.

X. PRIMARY CARE CASE MANAGEMENT
(Including "2175" waivers)

1. **Prepaid and Managed Care Under Medicaid: Characteristics of Current Initiatives**
   Squarrell, Karen I.; Hansen, Suzanne M.; and Neuschler, Edward. National Governors' Association, October, 1985.

   This report describes state initiatives in the areas of prepaid health care and primary care case management for acute care for the Medicaid population. It is intended to serve as a resource and reference for states that are developing, or considering whether to develop, such initiatives, and to make available to state Medicaid agencies and other interested parties relatively detailed information on the managed health care initiatives being undertaken in each state.

2. **Containing Medicaid Costs and Improving Services Through Primary Care Networks: The Kansas Experience**
   Levy, Mark. New England Journal of Human Services 5 (Summer 1985) 26-29.

   This article describes the Kansas pilot program, the Primary Care Network, that is intended to contain or reduce Medicaid costs without reducing services.

3. **Evaluating State Medicaid Reforms**
   Haynes, Pamela L. American Enterprise Institute, 1985.

   This publication presents a summary overview of case studies of seven demonstration projects, that are being implemented in six states and are funded by the U.S. Department of Health and Human Services. The case studies trace the beginnings of the programs as well as the mid-course corrections required to change the way providers, persons eligible for Medicaid, and those administering Medicaid work with the program.

4. **Summary of Case Studies of Medicaid Competition Demonstration Projects**
Haynes, Pamela L. American Enterprise Institute (Prepared Under Subcontract to the Research Triangle Institute), June 1985.

As part of an ongoing evaluation of Medicaid competition demonstrations, sponsored by the Health Care Financing Administration, this overview describes and contrasts features of Medicaid demonstrations included in a series of case studies.

5. **Focus on: Primary Care Case Management in Medicaid Programs**
Intergovernmental Health Policy Project, June 1984.

This Focus On describes some primary care case management programs in Arizona, California, Colorado, Kentucky, Michigan, New York, New Jersey, and Tennessee. The publication analyzes four issues related to primary care case management including cost, utilization, patient access and quality of care.

6. **Medicaid Reform: Four Studies in Case Management**
Freund, Deborah A. American Enterprise Institute, 1984.

In-depth case studies of four Medicaid case management initiatives (Michigan, Kentucky, Utah and Santa Barbara, California), assessing the promises and the problems associated with this new form of health care delivery are presented.

7. **Medicaid Freedom of Choice: A Review of Waiver Applications under Section 2175 of the Omnibus Reconciliation Act of 1981**
Bartlett, Lawrence. National Governors' Association, August 1982.

This report presents a review of waiver applications including various approaches such as primary care case management, localities serving as brokers, sharing of cost savings with recipients and restricting recipients to cost effective providers.

8. **Medicaid and Primary Care Networks**
National Governors' Association; March 1982.

Presented is a concept paper and the proceedings of the National Governors' Association Conference (December 2, 1981) on Medicaid and Primary Care Networks. The publication covers topics such as private sector experience with Primary Care Networks (PCNs), the experience of PCNs caring for an indigent population, and selected Medicaid agencies' plans for implementing PCNs.

9. **Waiver of Medicaid Freedom-of-Choice Requirement: Potential Savings and Practical Problems**
U.S. General Accounting Office (GAO), July 20, 1982.

GAO reviewed the Medicaid freedom-of-choice requirement to determine whether savings can be achieved and to identify the practical problems that may be encountered if freedom of choice were eliminated and the services were furnished by lower cost providers.

XI. QUALITY ASSURANCE AND QUALITY CONTROL

Information resources for this subject area are currently under development.

XII. REIMBURSEMENT - HOSPITAL

A. General

1. **Restoring Meaning to the "Disproportionate Number" Provision**
Wilson, Susan, and Waxman, Judith. Clearinghouse Review, National Health Law Program, December 1984.

After examining the federal statute, federal regulations and state Medicaid plans, this paper finds that HCFA and most state Medicaid agencies are not properly implementing the Social Security Act with respect to the "disproportionate number" provision. Also included is a discussion as to how to make this provision more effective in states.

2. **Hospital Merger Increased Medicare and Medicaid Payments for Capital Costs**
U.S. General Accounting Office (GAO), December 22, 1983.

Pursuant to a congressional request, GAO investigated the acquisition of the assets of Hospital Affiliates International, Inc. by the Hospital Corporation of America. GAO used the merger as an example of changes in hospital costs under current Health Care Financing Administration (HCFA) Medicare policies for reimbursement of capital expenses after changes in hospital ownership. GAO focused on changes in interest, depreciation, and home office expenses because these costs are most likely to increase as a result of such acquisitions.

3. **Medicaid Payment for Hospital Services: Plain Talk About What Has Happened and What Should Be Done**
American Hospital Association, Chicago, Illinois, November 1983.

Proceedings of four regional conferences, convened to discuss the impact OBRA, has had on state approaches to payment for hospital services, are presented. Statistical trends, as well as general trends which reflect how states have adapted to OBRA, are included.

4. **What Price Cost Control? Massachusetts' New Hospital Payment Law**
Caper, Philip and Blumenthal, David. New England Journal of Medicine. 508 (March 3, 1983) 542-544.

A description of Chapter 372 of Massachusetts' law governing payments to hospitals. The new law is intended to improve the health care system by (1) reversing the growth of overall hospital spending; and (2) limiting perceived inequities in the allocation of hospital costs among private insurance companies, Blue Cross, the Medicare and Medicaid programs, and privately paying patients.

5. **Nursing Homes, Hospitals and Medicaid: Reimbursement Policy Adjustments 1981-82**
Spitz, Bruce, and Atkinson, Graham. National Governors' Association (NGA), March 1983.

The paper reviews a national profile of reimbursement activity, based upon a survey conducted by NGA. It includes the specific reimbursement experiences of several selected states, as well as recommendations for improvements in state nursing home and hospital reimbursement programs.

B. Diagnosis-Related Groups (DRGs) and Prospective Systems

1. **Medicaid DRG Hospital Reimbursement Systems: A Technical Guide for State Implementation**
Vertrees, James C., and Bartlett, Lawrence. National Governors' Association, June 1985.

This technical guide provides a range of information states may use in developing a DRG-based hospital reimbursement system for their individual state Medicaid programs. The report is organized to allow different audiences access to information of particular relevance to them. Included are chapters on: (1) the basic elements of a DRG-based system; (2) the process of developing and implementing a DRG system; (3) the extensive data base development and analysis needed to create DRG rates; and (4) modifications a state may need to make in related program areas.

2. **DRGs and the Medicaid Program**
Zimmerman, Donald L. Intergovernmental Health Policy Project, June 1984.

This paper explores the possibility and potential consequences of using a DRG- prospective payment system for financing inpatient hospital services for the Medicaid population. The analysis is intended to help determine whether a DRG type system is an appropriate methodology for containing the costs of inpatient care under Medicaid.

3. **Coverage of Uncompensated Care Under Prospective Hospital Reimbursement Systems**
National Health Law Program, May 11, 1984.

This report describes uncompensated care coverage under prospective hospital reimbursement systems in New Jersey, New York, Massachusetts, and Maryland and includes strengths and weaknesses of existing reimbursement methods and their effects on both the poor and hospitals.

C. Selective Contracting

1. **Selective Contracting for Health Services in California: Final Report**
Johns, Lucy, Derzon, Robert, A.; and Anderson, Maren. National Governors' Association and Lewin and Associates, Inc., March 5, 1985.

This Final Report addresses the second full year of selective contracting in California, including the second round of Medi-Cal hospital negotiations. Savings in the first year are documented, and available information on recipient impact (access, quality) is summarized. Private sector preferred provider arrangements have now developed more fully and are reviewed in detail. The report assesses the impact of both initiatives on the practice of medicine, the hospital sector, the health insurance marketplace, employee health benefits, and the statewide health delivery system.

2. **Selective Contracting for Health Services in California: First Report**
Johns, Lucy; Derzon, Robert A.; and Anderson, Maren. Lewin and Associates, Inc. and National Governors' Association, December 27, 1983.

This report presents an analysis of California's earliest experience with selective contracting. It reports findings in five areas: (1) history and early expectations; (2) implementation of Medi-Cal contracting for inpatient hospital services in the first year; (3) impact of contracting on the hospital sector; (4) impact on the health insurance market place; and (5) impact on the statewide health delivery system.

3. **Creating the Medicaid Marketplace: Selective Contracting in California's Medi-Cal Programs**
Zimmerman, Don. Intergovernmental Health Policy Project, July 1983.

This article presents a discussion as to whether California's Medi-Cal reforms (selective contracting) are transferable to other states.

4. **Competition in the Health Care Marketplace: A Beginning in California**
Melia, Edward, P. et al. The New England Journal of Medicine 308 (March 31, 1983) 788-792.

This report on California's selected contracting for hospitals and physicians includes a description of the program, and the authority given to private insurers to contract with providers at alternative (to fee-for-service) rates, if the benefits of those rates are passed on to subscribers in the form of lowered premiums. Also included are projections for the future of the program, as well as a discussion of unresolved issues and unanswered questions.

XIII. REIMBURSEMENT - NURSING HOMES

1. **State Rate-Setting and Its Effect on the Cost of Nursing-Home Care**
Holahan, John. The Urban Institute, Journal of Health Politics, Policy and Law 9 (Winter 1985) 647-667.

This paper, using data from nursing home cost reports, analyzes the effectiveness of different approaches to nursing home reimbursement.

2. **Reimbursement of the Capital Component of Nursing Home Care: Options for the Pennsylvania Medicaid Program**
Bartlett, Lawrence. Health Systems Research, Inc., Washington, D.C., August 1984.

The purpose of this report is to assist the state in analyzing alternative proposals for identifying optional capital reimbursement approaches for public programs such as Medicaid. Four alternative capital reimbursement methodologies are analyzed in this report.

3. **Nursing Homes, Hospitals and Medicaid: Reimbursement Policy Adjustments 1981-1982**
Spitz, Bruce, and Atkinson, Graham. National Governors' Association (NGA), March 1983.

This paper reviews a national profile of reimbursement activity based upon a survey conducted by NGA. It includes the specific reimbursement experiences of several selected states, as well as recommendations for improvements in state nursing home and hospital reimbursement programs.

4. **Health Care Financing Grants and Contracts Reports: An Overview of Medicaid Nursing Home Reimbursement in Seven States**
Office of Research and Demonstrations, Health Care Financing Administration, U.S. Department of Health and Human Services, October, 1981.

This report analyzes the way in which nursing home reimbursement policy has been made and applied at the state level. Specifically, the politics and economics of nursing home reimbursement in seven states were examined.

5. **Health Care Financing Grants and Contracts Reports: Medicaid Nursing Home Reimbursement: New York, Illinois, California Care Studies**
Office of Research and Demonstrations, Health Care Financing Administration, U.S. Department of Health and Human Services, October, 1981.

This report presents an analysis of nursing home reimbursement systems and experiences in three large states. (Most data is from the mid to late 1970s).

XIV. REIMBURSEMENT - PHARMACY

1. Capitation for Pharmacy Services

I. Impact on Drug Use and Pharmacist Dispensing Behavior

Yesalis, Charles et al. Medical Care 22 (August 1984) 737-745.

II. Impact on Costs

Yesalis, Charles, et al. Medical Care 22 (August 1984) 746-754.

These articles present findings of a review of the Iowa Medicaid program's capitated pharmacy reimbursement program.

2. Pharmaceutical Reimbursement and Drug Cost Control: The MAC Experience in Maryland

Sawyer, Darwin O. Inquiry 20 (Spring 1983) 76-87.

This article presents a strategy for identifying Maximum Allowable Cost (MAC) program impacts with a focus on actual changes in drug expenditures. Maryland's MAC program is hightlighted to illustrate how program impact can be assessed through a review of spending patterns over time.

3. Evaluation of the Maximum Allowable Cost (MAC) Program

Lee, A. James, et.al. Health Care Financing Review 4 (March 1983) 71-82.

Through a review of the MAC program in several states, the cost savings potential of this program was illustrated.

XV. REIMBURSEMENT - PHYSICIAN

1. **Access to Private Obstetrics/Gynecology Services Under Medicaid**
Mitchell, Ph.D., Janet B., and Schurman, Rachel, M.A. Medical Care 22 (November 1984) 1026-1037.

Medicaid participation of physicians in three specialties, general surgery, ob-gyn and pediatrics, were examined. Findings indicate an exceptionally low rate of participation in Medicaid of ob-gyn physicians suggesting a potential problem with access to ob-gyn services. Factors influencing low physician participation were discussed.

2. **Medicaid Participation by Medical and Surgical Specialists**
Mitchell, Ph.D., Janet B., Medical Care 21 (September 1983) 929-938.

This study examined Medicaid participation rates of physicians in nine medical and surgical specialities and identified factors encouraging participation.

3. **Relationship of Physician Medicaid Reimbursement in Private Practice and Hospital Outpatient Departments to Actual Costs of Providing Care**
Leon, Joanna, et al. Brandeis University, Waltham, Massachusetts, 1983.

This study compares the mix and cost of patients treated in hospital outpatient departments with those treated in private physicians' offices. Presenting diagnoses do not markedly differ between these settings, but these differences generate costs in one type of setting which substantially differ from those in others. (Abstract from NTIS, Health Planning and Health Services Research, August 16, 1983, p. 192)

XVI. RELATED PUBLIC POLICY ISSUES

1. **Intergovernmental Options for Reducing Infant Mortality: Proceedings from a Conference, September 13-15, 1984.**
Intergovernmental Health Policy Project (IHPP), 1985.

   The report includes the proceedings of a conference convened by IHPP with support from the United States Public Health Service for the purposes of (1) providing a forum for participants to discuss their programs for improving maternal and infant health and sharing their successes and failures; (2) enabling federal, state and local government representatives to explore ways to more effectively coordinate their efforts to reduce infant mortality and morbidity; and (3) promoting dialogue between the various levels of government and private organizations.

2. **The Effects of Litigation on Health Care Costs**
Hunsaker, Ann T., et al. The Brookings Institute, Washington, D.C., April, 1984.

   The publication contains six major papers presented at the conference entitled, "The Effects of Litigation on Health Care Costs," and highlights each panel discussion with conference participants.

3. **Changing Social Welfare Policies: An Update of their Effects on State and Local Programs: Conference Summary**
Menges, Joel, and Hackbarth, Marie. American Enterprise Institute, March 20-21, 1984.

   This seminar summary discusses the effects of changes in federal policies on state and local programs; what groups and locales have been most seriously effected; and how federal funds are being replaced.

4. **The Future of Medicaid Technology in a New Payment Environment: Conference Summary**
Hackbarth, Marie, et al. American Enterprise Institute; January 23, 1984.

   This conference summary presents an analysis of the following issues: what will happen to medical technology in a cost-cutting environment;

what will happen to quality and accessability of care; and what are the medical and public policy implications of technological advances.

5. **Passing the Health Care Buck: Who Pays the Hidden Cost?**
Meyer, Jack A.; Johnson, William R.; and Sullivan, Sean. American Enterprise Institute, 1983.

This paper presents a discussion of "cost shifting" in terms of: who pays; alternatives to finance the Medicaid/Medicare shortfall, including the nature and dimensions of the cost shift; the cost shift compared with income and payroll taxes; other financing alternatives such as a tax-subsidy cap and an excise tax; and responses to the cost shift and recommendations for reform.

6. **State Comprehensive and Catastrophic Health Insurance Programs: An Overview**
Ellet, T. Van. Intergovernmental Health Policy Project (IHPP), October 1, 1981.

The purpose of this monograph is to provide both federal and state policymakers with a brief overview of state comprehensive/catastrophic programs, detail how they are structured and, to a limited degree, explain what their experience has been.

XVII. THIRD PARTY LIABILITY (TPL)

1. **Report to the Congress by the Comptroller General of the United States. Improved Efforts Needed to Relieve Medicaid From Paying for Services Covered by Private Insurers**
U.S. General Accounting Office (GAO), February 12, 1985.

   GAO reviewed the administration of Medicaid programs by six states to assess the extent and effectiveness of their efforts to reduce Medicaid program costs by using other available health care resources. In addition, GAO described how state Medicaid practices for identifying and collecting private health insurance could be improved through more oversight by the Health Care Financing Administration (HCFA).

2. **Third Party Liability in the Medicaid Program: A Guide to Successful State Agency Practices**
Health Care Financing Administration, U.S. Department of Health and Human Services, November 1984.

   A "Best Practices" guide which provides information on practices in the area of TPL, including both cost avoidance and pay and chase approaches. The Guide provides the reader with a brief summary of each practice and references key TPL personnel in the state agencies who can be contacted for further information.

XVIII. UTILIZATION CONTROL

1. **The Effect of a Medicaid Drug Copayment Program on the Utilization and Cost of Prescription Services**
Nelson, Ph.D., Arthur A., et al. Medical Care 22 (August 1984) 724-735.

The effect of a copayment for pharmaceutical services in the South Carolina Medicaid program was compared to the Tennessee Medicaid program which does not have a copayment provision for pharmacy services. The study concluded that a small copayment amount for pharmacy services is a successful mechanism to control the cost and assist in financing Medicaid prescription drug program costs.

2. **The Impact of Outpatient Department and Emergency Room Use on Costs in the Texas Medicaid Program**
Fleming, Ph.D., Neil S., and Jones, Ph.D., Hubert C. Medical Care 21 (September 1983) 892-910.

1980 data from the Texas Medicaid program were examined and findings are presented which indicate OPD/ER visits are more costly than physician visits. Also included are data regarding hospitalization rates, total episodic costs of the two groups and lengths of hospital stays.

3. **Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs**
Iannon, Diane and Bartlett, Lawrence. National Governors' Association and the New York State Department of Social Services, June 1983.

This paper presents the findings of a survey of state lock-in programs, including how possible over-utilizers are identified, how lock-in recipients are selected, selection of a primary provider, responsibilities of a primary provider, the duration of the restriction, gross savings under a lock-in program, administration costs and net savings, and comparsion of savings with prior authorization programs.

4. **Improving Medicare and Medicaid Systems To Control Payments for Unnecessary Physicians' Services**
U.S. General Accounting Office (GAO), February 8, 1983.

GAO reviewed the Medicare and Medicaid programs to assess the mechanisms that paying agents under these programs are using to identify and prevent reimbursement to physicians and suppliers for medically unnecessary services and to recoup payments made for such services. The objectives of the review were to: (1) assess and compare the costs and benefits of the prepayment and postpayment utilization review (UR) functions and a representative number of carriers and state Medicaid agencies; (2) identify probable causes for the variations in the performance of these UR functions; and (3) evaluate the Health Care Financing Administration's (HCFA) role, particularly under Medicare, in providing direction to these activities.

5. **Controlling Medicaid Costs: Second Surgical Opinion Programs**
Roenigk, Dale, and Bartlett, Lawrence. National Governors' Association, November, 1982.

This report reviews the applicability of certain utilization control techniques; presents evidence that surgery may be overutilized and possible reasons; and examines second surgical opinion programs in seven states, including the process and impact of such programs.

INDEX OF WRITTEN MATERIAL ON MEDICAID

ATTACHMENT:

ADDRESSES OF SELECT ORGANIZATIONS THAT PUBLISH MEDICAID-RELATED MATERIAL

American Enterprise Institute (AEI)
1150 Seventeenth Street, N.W.
Washington, D.C. 20036
(202) 862-5869 or
1-800-424-2873

General Accounting Office (GAO)
Document Handling and Information Service
P.O. Box 6015
Gaithersburg, Maryland 20877
(202) 275-6241

Publications Office
Office of Research and Demonstrations
Health Care Financing Administration
2-E-6 Oak Meadows Building
6340 Security Boulevard
Baltimore, Maryland 21207
(301) 597-2422

Intergovernmental Health Policy Project (IHPP)
2100 Pennsylvania Avenue, Suite 616
Washington, D.C. 20037
(202) 872-1445

National Association of State Mental
Retardation Program Directors, Inc. (NASMRPD)
113 Oronoco Street
Alexandria, Virginia 22314
(703) 683-4202

National Conference of State Legislatures (NCSL)
1125 Seventeenth Street, Suite 1500
Denver, Colorado 80202
(303) 292-6600

National Governors' Association (NGA)
Health Policy Studies
Center for Policy Research
444 No. Capitol Street
Washington, D.C. 20001
(202) 624-5300

or

State Medicaid Information Center (SMIC)
(202) 624-7812

National Health Law Program (NHeLP)
1302 Eighteenth Street, N.W., Suite 701
Washington, D.C. 20036
(202) 887-5310

The Urban Institute
Library/Information Clearinghouse
P.O. box 7273, Dept. C
Washington, D.C. 20044
(202) 857-8688

or

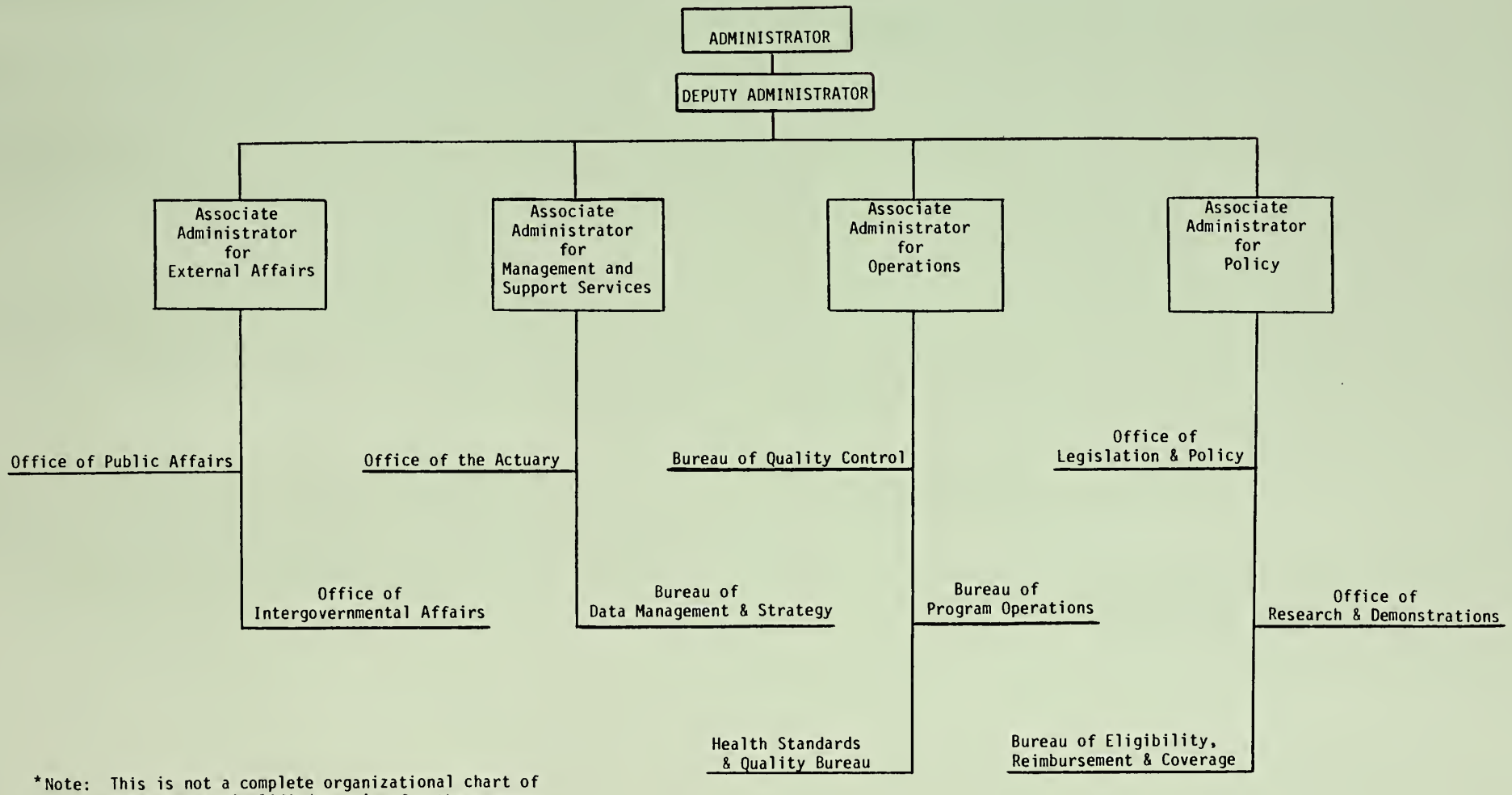
2100 M Street, N.W.
Washington, D.C. 20037
(202) 833-7200

HCFA DIRECTORY

TABLE OF CONTENTS

SUBJECT INDEX

HCFA ORGANIZATIONAL CHART *



*Note: This is not a complete organizational chart of HCFA, but a simplified version for the purpose of this directory.

NOTE:

The information which follows is provided to state Medicaid agencies in order to facilitate access to resources and staff within HCFA's Central Office when such access is appropriate. It in no way alters or supplants the existing network and working relationships between state Medicaid agencies and HCFA regional offices.

HCFA MEDICAID PROGRAM FUNCTIONAL RESPONSIBILITIES AND CONTACT PERSONS

I. OFFICE OF THE ADMINISTRATOR

A. OFFICE OF EXECUTIVE OPERATIONS

1. REGULATIONS MANAGEMENT OFFICE

- Coordinates regulations development and clearance process within HCFA
- Upon request, will make available copies of public comments on proposed regulations (a minimal fee may be charged to cover the costs of xeroxing and handling)
- Will provide information necessary to locate regulations published in the Federal Register

Inquiries should be directed to:

Rozann Abato, Director
Office of Regulations Management
309G Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201
(301) 597-4462

II. OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR EXTERNAL AFFAIRS

A. OFFICE OF INTERGOVERNMENTAL AFFAIRS

- The primary function of the Office of Intergovernmental Affairs is to develop and maintain effective communications with state and local governments so that dialogue with and input from these units of government can be obtained on HCFA policy development. The Office also maintains communication with organizations representing states such as the American Public Welfare Association, the National Governors' Association and the National Conference of State Legislatures.

Inquiries should be directed to:

Henry Spiegelblatt (202) 245-6258
Milton Dezube (202) 245-6257
Joe Baker (202) 472-7413

Office of Intergovernmental Affairs
Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

B. OFFICE OF PUBLIC AFFAIRS

- Receives and handles all requests under the Freedom of Information Act. Requestors may be state Medicaid agencies, individuals referred by state Medicaid agencies, the general public, etc.

- Handles all requests for public information pertaining to programs within HCFA's jurisdiction

- Will assist a state Medicaid agency (or any other individual or organization) locate the appropriate contact/office within HCFA or here to whom specific inquiries can be directed

- Develops and disseminates public information materials (e.g. brochures, pamphlets) pertaining to the various programs within HCFA's jurisdiction and targeted to a variety of audiences. Upon request, Public Affairs will make available to state Medicaid agencies copies of Medicaid program-specific materials for distribution. Additionally, Public Affairs will offer assistance to state Medicaid agencies wishing to develop their own public information material

Inquiries should be directed to:

Dennis Siebert, Director
619 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-4323 or (202) 245-6113

III. OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR MANAGEMENT AND SUPPORT SERVICES

A. OFFICE OF THE ACTUARY

1. DIVISION OF MEDICAID COST ESTIMATES

a. Medicaid Estimates Branch

- Provides cost estimates for the Medicaid program including development of cost estimates for proposed changes in Medicaid or in programs affecting Medicaid, and overall program costs for years after the current budget year

- Provides actuarial consultation to HCFA components, the states and other organizations with respect to the Medicaid program

Inquiries should be directed to:

Stephen Meskin, Chief
2-C-7 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 597-3198

b. Medicaid Statistics Branch

- o Collects routine annual Medicaid program statistical reports (HCFA-2082) from state Medicaid agencies
- o Works with the respective agencies to correct errors and collect missing information
- o Conducts consistency checks across data bases to verify validity of submitted data and makes corrections to current and historical data to produce accurate statistics

Inquiries should be directed to: Rick Beisel, Chief
2-C-7 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 597-1417

B. BUREAU OF DATA MANAGEMENT AND STRATEGY (BDMS)

1. OFFICE OF COMPUTER OPERATIONS

- o Responsible for receipt and processing of Medicaid data tapes received from state Medicaid agencies

Inquiries should be directed to: John Zurad, Director
User Support Division
G-A-2 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 597-2999

2. OFFICE OF INFORMATION RESOURCE MANAGEMENT

- o coordinates HCFA-wide activities related to new future Medicaid data initiatives including data tape options and HMO data

Inquiries should be directed to: Frank Lee, Program Analyst
G-A-2 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 597-2127

IV. OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR OPERATIONS

A. HEALTH STANDARDS AND QUALITY BUREAU (HSQB)

1. OFFICE OF MEDICAL REVIEW

- Primarily involved with the Professional Review Organization (PRO) program for Medicare. Will discuss issues and policies relative to state Medicaid agencies privately contracting with existing PROs to fulfill Medicaid medical review needs and requirements

Inquiries should be directed to: Tim Carr, Special Assistant
1-K-3 Dogwood East
1849 Gwynn Oak Avenue
Baltimore, MD 21207
(301) 594-1325

2. OFFICE OF SURVEY AND CERTIFICATION

- Functionally responsible for laws, regulations, policies and procedures that are applied by state survey agencies (SAs) to determine provider compliance with Medicaid survey and certification requirements

- Provides guidance on existing requirements to regional offices who in turn work directly with the SA to ensure uniform interpretation and application of program requirements

- The SA determines provider compliance with Medicaid requirements through onsite reviews of provider institutions and certifies its findings to the state Medicaid agency. State Medicaid agency questions regarding SA interpretations or determinations should be forwarded to the SA

- The Office of Survey and Certification does not feel it is appropriate for state Medicaid agencies to contact this office directly. All inquiries should be directed to the SA or to the appropriate Regional Office

B. BUREAU OF PROGRAM OPERATIONS

1. OFFICE OF FINANCIAL OPERATIONS

a. Division of State Agency Financial Management (DSAFM)

The DSAFM directs and coordinates the fiscal aspects of the Medicaid program in three major functional areas of responsibility:

- Establishes the policies and procedures by which the Medicaid State agencies submit the Medicaid Program Budget Report (Form HCFA-25) and formulates the national Medicaid budget

- Establishes the policies and procedures by which the Medicaid State agencies submit the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form HCFA-64) and prepares and issues of all Medicaid grant awards (Forms HCFA-L-151 and L-152)

- Establishes the operational policies regarding the availability of Federal financial participation (FFP) under the Medicaid program

Inquiries should be directed to:

David McNally, Director
350 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 597-1398

i. Budget Branch

- Responsible for all aspects of the Medicaid Program Budget Report (Form HCFA-25) including: developing related policies and procedures for Medicaid State agencies and Regional Offices, analyzing Medicaid budget estimates and trends, and formulating the national Medicaid budget

Inquiries should be directed to:

John Lemieux, Chief
350 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 594-6876

ii. Grants Branch

- Responsible for all aspects of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form HCFA-64) and the Medicaid grant awards (Forms HCFA A-L-151 and L-152) including: developing related policies and procedures for Medicaid State agencies and Regional Offices, reviewing all expenditure reports to evaluate budget execution and determine the allowability of costs, and administering the State grant process through the preparation and issuance of all Medicaid grant awards.

Inquiries should be directed to:

Bill Mulligan, Chief
350 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 594-7413

iii. Financial Policy Branch

- Responsible for all aspects of operational policy regarding the availability of FFP under the Medicaid program including: reviewing and approving all disallowances of State claims for Medicaid reimbursements, preparing defense of disallowance decisions before Grant Appeals Board (GAB) and implementing all GAB decisions, setting and interpreting fiscal requirements and procedures for use by States and regional offices, developing instructions for the financial review of the Medicaid program, providing interpretations of cost reimbursement policy, and issuing interpretations regarding operational FFP issues.

Inquiries should be directed to:

Bill Lasowski, Chief
350 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 597-1301

2. OFFICE OF PROGRAM ADMINISTRATION

a. Division of Operational Initiatives

i. Policies and Procedures Branch

- Responsible for developing regulations and procedures for state Medicaid agencies in the operations of Third Party Liability (TPL) programs.
- Recently published and distributed to state Medicaid agencies Third Party Liability in the Medicaid Program: A Guide to Successful State Agency Practices.

Inquiries should be directed to:

Herb Shankroff, Chief
367 Meadows East
6300 Security Boulevard
Baltimore, MD 21207
(301) 594-6710

3. OFFICE OF PROGRAM OPERATIONS PROCEDURES

a. Division of Medicaid Procedures

- Develops requirements, standards, procedures, guidelines, and methodologies pertaining to the review, evaluation, and assessment of the operations, development, and funding of State agency automated systems to determine their compliance with published Federal requirements. Reviews State agency MMIS for approval of increased Federal financial participation (FFP) and establishes technical specifications for Electronic Data Processing procurements

- Directs the development and issuance of regulations, specifications, requirements, procedures, functional standards, and instructional material to implement and maintain operational systems for processing Medicaid claims and defines their application to states and beneficiaries of HCFA programs

- Integrates systems within the framework of HCFA policies, goals, and objectives in an efficient and cost-effective manner. Develops and directs the implementation of data initiatives which will promote efficiency and uniformity in Medicaid operations. Develops standards for cost and benefit analysis and monitoring of Medicaid Management Information System (MMIS) design, development, installation, and operations. Develops and implements a program for the exchange of information to improve the operation of MMIS systems, methods, and procedures including conferences and other media and serves as HCFA focal point for contact with States and the private sector on MMIS issues

Inquiries should be directed to:

Guy Harriman, Director
G357 Meadows East
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-4880

i. Operations Branch

- Reviews state agency MMIS, including automated eligibility systems, for approval of increased FFP. Serves as a clearinghouse for technical innovations and cost-effective methodologies pertaining to the state of the art in electronic data processing development. Develops and implements an information exchange program to improve the operation of MMIS methods and procedures. Serves as a focal point for Medicaid funding requests and coordinates with the appropriate components within HCFA and the Department

Inquiries should be directed to: Dan Boyle, Chief
1-H-2 Meadows East
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-6644

ii. Systems Development Branch

- Plans, conducts, and evaluates studies aimed at long-range improvements in systems, methods, and procedures as they relate to the administration of the Medicaid program and integration of systems within the framework of HCFA policies, goals, and objectives. Performs national oversight for MMIS related activities. Develops, directs, and coordinates systems plans and studies for the effective integration of all Medicaid automated processing systems at the state agency level. Acts as liaison to Systems Technical Advisory Groups (STAG) and Private Sector Users Group (PSUG) on MMIS issues. Furnishes technical assistance to these groups and to fiscal agents. Manages the Bill Processing Systems Test (BPST) program

Inquiries should be directed to: Nelson Berry, Chief
G-C-7 Meadows East
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-4884

iii. System Management Branch

- Develops national guidelines establishing the requirements for various levels of FFP in state Medicaid operations. Develops standards for cost/benefit analyses and the monitoring of Medicaid Management Information Systems (MMIS) design, development, installation, and operations. Develops and approves cost allocation plans involving multiple Departmental Operating Divisions. Analyzes expenditure data for variations among state operations

Inquiries should be directed to: John Mullen, Chief
G-D-3 Meadows East
6325 Security Boulevard
Baltimore, MD 21207
(301) 597-1155

iv. Requirements Branch

- Directs the development and issuance of regulations, specifications, requirements, procedures, and instructional material to implement and maintain operational systems for processing Medicaid claims and defines their application to states and program beneficiaries. Develops and maintains the general systems design process for the detailed design and programming of model automated Medicaid claims processing systems. Maintains and issues revisions to the State Medicaid Manual. Develops and manages the implementation of Medicaid data initiatives such as uniform billing and common coding designed to promote efficiency and uniformity in the administration of state Medicaid program directives. Develops functional standards and requirements for use when conducting certifications of state MMIS

Inquiries should be directed to: Wes Baker, Chief
1-H-3 Meadows East
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-9155

C. BUREAU OF QUALITY CONTROL (BQC)

1. OFFICE OF QUALITY CONTROL PROGRAMS (OQCP)

- Focuses on core program functions (such as claims processing, institutional payments and eligibility determinations) that merit ongoing uniform and structured review

- Included among Medicaid program reviews are:

  - a multi-leveled review program of state's institutional reimbursement program (hospital or long-term care facility)
  - a statistically-based program measuring a state's accuracy in determining recipient eligibility
  - a review of a state's Medicaid Management Information System (MMIS) to determine if the state should continue to receive enhanced Federal funding
  - claims review to determine whether a state needs to implement a comprehensive system to ensure future accuracy or may be allowed to run a simpler system which it may design itself within broad Federal parameters
  - a check to assure all institutional beneficiaries are receiving the correct level of care and have updated plans of care

- o Results of the above-mentioned reviews are used:
  - to impose sanctions
  - in the comparative analysis of states, through the State Medicaid Operation Review (SMOR)
  - to identify and document systemic problems that may require more intensive analysis for policy or operational reform

Inquiries should be directed to:

Joyce Somsak, Director
239 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 597-1354

2. OFFICE OF PROGRAM QUALITY EVALUATION (OPQE)

- o Conducts stategic analyses for BQC which lead to decisions on the balance between Medicaid/Medicare relative efforts and the areas of concentration within those programs

- o Manages Medicaid Data Validation Review program and processes data concerning administrative functions such as claims processing

- o Prepares reports to Congress on abortions funded under Medicaid

- o Currently involved in assisting three states through the operation of the Nursing Home Reporting System. This system enables states to see profiles of all the services rendered to Medicaid patients in nursing homes. States can then detect duplicate charges to Medicare (OPQE takes care of incorporating the Medicare data) and aberrant utilization patterns within Medicaid (such as overprescribing of drugs). The states participate by providing tape copies of bill histories to BQC and BQC staff processes the data through HCFA software and presents hard copies back to the states

Inquiries should be directed to:

William Hickman, Director
239 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 597-6369

3. OFFICE OF OPERATIONAL REVIEWS (OOR)

- o Focuses on the comparative analysis of state and contractor performance and indepth analyses of selected program and policy issues

- o Performs State Assessments - a review of state performance in managing the Medicaid program. Results are integrated into a comprehensive report on each state

- Directs and implements the Contractor Performance Evaluation Program (CPEP) which parallels the State Assessment process. Results are combined with findings from OQCP programs

- Performs Operational Reviews as requested by the HCFA Administrator and policy and operational components within HCFA. These are indepth reviews performed for selected issues that may require policy or operational reform. Also evaluated are the implementation of policy and procedures

Inquiries should be directed to: Joe Hladky, Director
239 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-8470

V. OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR POLICY

A. OFFICE OF LEGISLATION AND POLICY

1. OFFICE OF LEGISLATION

- Will provide information on the status of newly-introduced and pending legislation/bills concerning Medicaid program issues. Copies of legislation are available through this office

Inquiries should be directed to: Nancy Null, Acting Director
Division of Medicaid Legislation
337 Humphrey Building
200 Independence Avenue S.W.
Washington, D.C.
(202) 245-8220

2. OFFICE OF POLICY ANALYSIS

- Responsible for development of the yearly legislative program related to Medicaid program and budget issues. General inquiries related to these issues should be directed to the HCFA Office of Intergovernmental Affairs. However, more specific and substantive questions regarding legislative proposals may be directed to this office

Inquiries should be directed to: Tom Alt, Director
339-H 200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 472-2117
OR
Thomas Gustafson, Chief
Medicaid Long Term Care Branch
339-H 200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 472-5240

B. BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE (BERC)

1. OFFICE OF ELIGIBILITY POLICY

a. Division of Medicaid Eligibility Policy

- o Develops, interprets and evaluates policies pertaining to:
  - conditions under which recipients are eligible to have their health care reimbursed under Medicaid
  - the post-eligibility process
  - rights of recipients and applicants
  - a variety of technical policy area
- o Evaluates the effect of proposed legislation on current eligibility policies and recommends specifications for new or proposed legislation on eligibility
- o Reviews eligibility aspects of Section 1115 demonstration projects in conjunction with the Office of Research and Demonstrations (ORD) and eligibility aspects of home and community-based waivers
- o Reviews and makes recommendations pertaining to approval and disapproval of freedom-of-choice waivers
- o Provides consultation to Regional Offices on state Plan amendments dealing with eligibility matters and prepares disapproval actions on state Plan amendments
- o Provides technical assistance to individual states and Regional Offices
- o Participates, upon request, on State Assessment teams and contributes to the development of assessment guides

Inquiries should be directed to: Marinos Svolos, Director
400 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-9050

i. Medicaid Eligibility Assessment Branch

- o The specific areas of functional responsibility for this branch of the Division of Medicaid Eligibility Policy are:
  - categorical requirements for eligibility including: dependency, age, blindness and disability
  - eligibility administration including: applications, determinations and determinations

- post-eligibility treatment of income
- state residency requirements
- third party liability and assignment of rights
- post-entitlement issues
- copayments
- Medicare/Medicaid Buy-In issues
- freedom-of-choice provisions and waivers
- beneficiary hearings and appeals
- adequacy of notices
- state eligibility profiles
- statewideness requirements
- single state agency requirements
- state plan/waiver procedures
- confidentiality and disclosure
- provider acceptance of payment in full

Inquiries should be directed to: Joyce Jackson, Chief
400 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 597-3870

ii. Medicaid Eligibility Branch

o The specific areas of functional responsibility for this branch of the Division of Medicaid Eligibility Policy are:

- mandatory coverage of the categorically needy
- optional coverage of the categorically needy
- optional coverage of the medically needy
- financial eligibility requirements including: spend down process, liens, transfer of assets, deeming, financial responsibility of relatives and medically needy income and resource levels
- Federal financial participation for services in public institutions
- eligibility for home and community-based services
- coverage in 209 (b) states
- SSI/Medicaid policy interface
- AFDC/Medicaid policy interface
- eligibility policies unique to children under 21 years of age

Inquiries should be directed to: Richard Coyne, Chief
400 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-8221

b. Hearings Staff

- o Provides hearing officers who conduct, on behalf of the Secretary, the Administrator and/or the Associate Administrator for Policy, hearings that are not within the jurisdiction of the Provider Reimbursement Review Board, the Office of Hearings and Appeals (SSA), the states or intermediaries

- o Types of hearings conducted include:

  - issues involving revocation of assignment privileges for physicians or suppliers determined to be in violation of their assignment agreement
  - administrative review of disapproved state Medicaid plans or amendments
  - those requested by court remand

Inquiries should be directed to: Lawrence Ageloff, Director
400 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-0346

2. OFFICE OF REIMBURSEMENT POLICY

a. Division of Alternative Reimbursement Systems

- o Assumes primary responsibility in formulating and evaluating policies for reimbursement of alternative methods of health service delivery requiring special methods of cost finding and apportionment

- o Establishes policies and principals for reimbursing services furnished in ambulatory settings such as hospices, "risk" and "cost-basis" health maintenance organizations, ambulatory surgery centers, etc.

- o Approves and verifies methodologies and used to determine reimbursement to hospitals, skilled nursing facilities and intermediate care facilities under the state Medicaid plan

Inquiries should be directed to: Anthony Lovecchio, Director
1A3 East Low Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-4010

i. Special Reimbursement Programs Branch

- o Develops policies and procedures related to approval and verification of Medicaid hospital reimbursement and prepares regulations, manuals and program guidelines related to these policies
- o Develops policies and procedures for Federal financial participation in state administrative costs related to development of alternative hospital or long-term care reimbursement methodologies or comprehensive health planning activities
- o Reviews and recommends approval or disapproval of state plans for inpatient hospital service reimbursement under a state Medicaid plan
- o Conducts special studies of the impact of reimbursement regulations on the use of alternative systems including state rate-setting
- o Reviews Medicaid state plan waivers regarding hospital reimbursement
- o Provides policy interpretations and technical assistance to Regional Offices and states

Inquiries should be directed to:

Bernie Truffer, Chief
1A3 East Low Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-9286

ii. Alternative Delivery Systems Reimbursement Branch

- o Develops policies and procedures pertaining to reimbursement of health maintenance organizations (HMOs), prepaid health care, rural health clinics and capitated systems
- o Reviews freedom-of-choice waivers involving prepaid and capitated systems
- o Involved in all aspects of HCFA policy activity concerning capitated payments and risk-based reimbursement arrangements
- o Provides policy interpretation and technical assistance to Regional Offices and states

Inquiries should be directed to: Jerry Hercenberg, Chief
1A3 East Low Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-8062

3. OFFICE OF COVERAGE POLICY

- Develops, reviews and evaluates Medicaid policies and procedures pertaining to:
  - coverage of theraputic and rehabilitative services such as skilled nursing and physical therapy
  - conditions of coverage for outpatient physical therapy, home health, personal care and day care services, and rehabilitative services
  - comparability and uniform availability of services (statewideness)
  - model waiver requests and waivers for the provision of home and community-based services
- Reviews Section 1915 (c) Medicaid State Plan waivers
- Reviews nature, quality and cost-effectiveness of home and community-based services to determine whether the waiver programs should be continued, modified or terminated
- Assists in the development of conditions of participation for home health agencies, providers of outpatient physical therapy and long-term care
- Involved in a range of activities related to alternative delivery systems and reimbursement including:
  - development of policies and procedures on Federal financial participation in state administrative costs relating to alternative reimbursement or comprehensive health planning activities
  - preparation of regulations, manuals and program guidelines related to these policies
  - review of policies developed by other HCFA components for their impact on alternative delivery systems and alternative reimbursement for hospitals and long-term care facilities
  - performance of studies on the impact of alternative modes of health care delivery on health care reimbursement

- participation in the development and evaluation of proposed legislation pertaining to alternative delivery or reimbursement systems

o Provides technical assistance and interpretations of established policies to Regional Offices and state Medicaid agencies

Inquiries should be directed to:

Robert Wardwell, Chief
Noninstitutional Services Branch
Division of Provider Services
Coverage Policy
429 East High Rise
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-9824

C. OFFICE OF RESEARCH AND DEMONSTRATIONS (ORD)

1. OFFICE OF DEMONSTRATIONS AND EVALUATIONS (ODE)

o Plans and directs the development, implementation, monitoring, and evaluation of demonstration projects designed to test the costs and effectiveness of alternative payment methods, delivery systems, benefit packages, or provider status in the Medicare and Medicaid programs. Develops and reviews innovative approaches to HCFA programs; coordinates with State and local Governments, providers, beneficiaries, researchers, and program staff in the implementation of projects; and assesses and synthesizes the results of projects to determine their impact on the programs and participants. Recommends modifications to existing program policy and legislation. Provides technical advice and consultation to other Federal and external organizations on potential experimental projects and publishes results and analyses of experimental findings.

Inquiries should be directed to:

Steven A. Pelovitz, Acting Director
2432 Oak Meadows
6325 Security Boulevard
Baltimore, MD 21207
(301) 597-3956

2. OFFICE OF RESEARCH (OR)

o Directs the development and conduct of research and evaluation studies concerning the impact of Federal financing programs on the health care industry, program beneficiaries, and health care providers; Directs and designs analytical studies to be undertaken by internal staff and outside contractors/grantees on a wide variety of economic and financial aspects of health care delivery. Makes available research findings to assist in the formulation of reimbursement and other policy questions and publishes results and analyses of these findings. Provides input into the design of HCFA data bases from the research

perspective and manages HCFA's survey activities as they relate to research and evaluations.

Inquiries should be directed to: Allen Dobson, Director
2430 Oak Meadows
6325 Security Boulevard
Baltimore, MD 21207
(301) 594-3690

3. OFFICE OF OPERATIONS SUPPORT (OOS)

- Directs and plans ongoing research publications and information resources programs. Participates with Departmental components in a wide range of experimental health care delivery projects. Performs claims adjudication, reimbursement, and data collection for demonstration projects.

- Responsible for compliation and, where appropriate, distribution of HCFA/ORD publications.

- Directs and manages information, rules and procedures for solicitation of grants and cooperative agreements. Specific information for submissions under each review cycle is published periodically in the Federal Register.

Medicaid Information and Assistance Project (MIAP)

a project of the American Public Welfare Association

MIAP BULLETIN

No. 1
May 1985

The Medicaid Information and Assistance Project (MIAP) is pleased to present you with the first edition of the MIAP Bulletin. As part of MIAP's commitment to facilitate state Medicaid agencies' access to critical information and technical assistance, the project has developed the MIAP Bulletin as a vehicle to transfer information to and promote technical assistance among the states.

The MIAP Bulletin will provide a concise description of recently published federal regulations and legislation, court cases, upcoming events and highlights of Technical Advisory Group (TAG) meetings. The Bulletin is not intended to provide comprehensive analyses of material but, rather, to identify key information and critical developments in the Medicaid field and refer states to sources of additional information, where appropriate.

The Bulletin will also serve to promote and facilitate the exchange of technical assistance among state Medicaid agencies. To this end, the Bulletin will include: (1) state requests for information and assistance; and (2) state initiatives of potential interest to other states, such as the publication of a national newsletter to share information among state and federal fraud and abuse personnel, highlighted in this Bulletin.

The Bulletin will be published on a monthly basis, or more frequently if the need arises. Space has been reserved in the MIAP Resource Directory for you to file issues of the Bulletin. We welcome suggestions for improvement, as well as contributions to the monthly issues. If you have a resource or a problem you would like to share with other states via the Bulletin, please contact Suzanne Hansen or Valorie Faretra-Marchant at APWA, 1125 15th Street, N.W., Washington, D.C. 20005. (202) 293-7550.

FEDERAL REGISTER HIGHLIGHTS

March 13, 1985
Final Rule: Home and Community-Based Services; 42CFR Parts 435, 536, 440.

The final rules: (1) provide that certain facilities must meet standards, including those established under section 1616(3) of the Social Security Act, if waiver services are to be provided

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in the facilities; (2) revise the equation that states must use to determine the cost effectiveness of their waiver programs; (3) clarify that these services are available, at a state's option, to both medically needy individuals and categorically needy individuals; (4) provide that all recipients who are eligible under a special income level will have their post-eligibility income treated in a comparable manner; (5) revise some aspects of the assurances and the documentation that states must provide in their waiver requests; (6) revise the effective date of an approved waiver; (7) establish a federal financial participation (FFP) limit for expenditures for home and community-based services; and (8) specify the hearings procedures that apply to waiver terminations.

March 14, 1985
Proposed Rule: Income and Eligibility Verification Procedures; 42 CFR Parts 431 and 435.

The proposed rules would require each state to establish a statewide income and eligibility verification system (SIEV) to manage the exchange of income data from federal sources to the states and among state agencies and local jurisdictions responsible for assistance programs. States will now be able to access information regarding unearned income from IRS.

States would be required to request the following: (1) state wage information from the State Wage Information Collection Agency; (2) information about net earnings from self-employment, wages and payment of retirement income; (3) unearned income available from IRS; (4) information about benefits and wages, and other information from state unemployment compensation agencies; and (5) other additional income, resource or eligibility information relevant to determination from agencies in the states, or other states.

March 19, 1985
Proposed Rule: Payments to Institutions; 42 CFR Parts 435, and 436.

The purpose of this proposed rule is to enable states to make more reliable and consistent predictions of an individual's income when making post-eligibility determinations for institutionalized individuals. When computing the income of institutionalized individuals, the rule would (1) permit states, at their option, to either continue to use total available income or project anticipated income using the average available amount of monthly income received by the individual over the

prior six month period; and (2) allow states to deduct "non-covered" medical expenses incurred by the recipient. Non-covered expenses would include services which are recognized under state law, but are not covered under the state plan, and services which exceed state plan limitations on amount, duration and scope.

April 3, 1985
Final Rule: Federal Financial Participation (FFP) for Inmates in Public Institutions and Individuals in an Institution for Mental Disease or Tuberculosis.

This final rule precludes the availability of FFP, from the date of admission through the date of discharge, for covered non-institutional services provided to individuals who are inmates of public institutions which are not medical institutions or to individuals under age 65 who are patients in institutions for mental disease or tuberculosis.

April 12, 1985
Proposed Rule: Treatment of Social Security Cost of Living Increases for Individuals Who Lose SSI Eligibility.

Based on a decision of the United States District Court for the Northern District of California, this proposed rule revises the way in which financial eligibility for Medicaid is determined for those individuals no longer eligible for Supplemental Security Income (SSI) due to receipt of cost of living increases (COLA's) under the Social Security Act.

April 12, 1985
Notice of New System of Records: Privacy Act of 1974.

HCFA is proposing to establish a new system of records, "Credit Reports for Medicaid Recipients," for the purpose of using credit bureaus to identify and/or verify the sources of income and resources of Medicaid recipients.

April 17, 1985
Final Rule: Utilization and Quality Control Peer Review Organization (PRO): Assumption of Medicare Review Functions and Coordination with Medicaid.

This final rule describes, among other things, the relationship that should exist between PRO's and state Medicaid agencies that contract with PRO's to perform review functions.

COURT CASES

Massachusetts Supreme Judicial Court, 394 Mass. 296, March 15, 1985.

The Rate Setting Commission, effective August 13, 1981, changed the rate at which hospitals are reimbursed for "administratively necessary days" (i.e., a day in which a recipient occupies but does not require an acute care hospital bed while awaiting placement in a lower level of care facility). This rate was declared invalid by the court due to the failure of the Commission to make assurances to HHS that the rates were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."

U.S. Court of Appeals, First Circuit, No. 84-1675, March 19, 1985.

The Massachusetts Medicaid program is not required to make direct payment to an independently owned laboratory located in a hospital; instead the program may pay the hospital, which then may pay the laboratory.

U.S. Court of Appeals, Fourth Circuit, No. 84-1062, March 20, 1985.

The validity of the West Virginia Hospital Rate Review Law (effective February 1, 1983) freezing hospital rates and limiting increases in a hospital's gross patient revenues to not greater than 12% per year was upheld.

U.S. District Court, Northern District of California, No. C-84-5979-SC, March 22, 1985.

When determining a nursing home patient's monthly income, Medi-Cal must allow individuals to deduct all expenditures for medical expenses not covered under Medi-Cal from their monthly income. The agency <u>cannot</u> set limits on the deductions allowed.

OF NOTE

GAO Report
No. HRD-85-22, March 1, 1985 "Eligibility Verification and Privacy in Federal Benefit Programs: A Delicate Balance."

The report deals with the issue of the need for eligibility verification v. the need for protection of privacy. The report is seen primarily as an instrument for raising the issues and

making suggestions as to which issues need further exploration, rather than making specific recommendations for resolution of the issues.

COMING EVENTS

Third Party Liability Conference
June 4-6, 1985
Americana Hotel
Kansas City, Missouri

Conference participants will include representatives from the federal government, Congress and the states. Items to be discussed will be the federal and congressional agenda regarding TPL activities in the future and a sharing of states' model practices in the area of TPL recovery.

For further information, please contact:

Herb Shankroff, Chief
Policies and Procedures Branch
Bureau of Program Operations
Health Care Financing Administration
367 Meadows East
6300 Security Boulevard
Baltimore, Maryland 21207
(301) 594-6710

National Association for Welfare
Research and Statistics Workshop
"Challenges for Changing Times"
July 21-24, 1985
The Cornhusker Hotel
Lincoln, Nebraska

The conference will present findings and information related to completed, in-progress and upcoming research activities in the social services field.

For further information, please contact:

Jo Shrewsbury
or
Pat Taft
National Association for Welfare
Research and Statistics
P.O. Box 94804
Lincoln, Nebraska 68509
(402) 471-3121

STATE EXCHANGE

Medicaid Surveillance and Utilization Review Units (S/URS) met in Denver, Colorado on March 7, 1985 to share information in a national conference. Thirty-five states were represented as well as HCFA, OIG, and members of computer companies. S/URS units are responsible for prevention and detection of fraud and abuse within the Medicaid programs. One result of this conference was the initiation of a quarterly newsletter that will share information with state and federal fraud and abuse personnel. This newsletter is being developed by the Colorado Department of Social Services S/URS Unit and it is anticipated that the first issue will be out in the middle of July, 1985. The newsletter will contain information from each Federal region, from the Office of the Inspector General and HCFA as well as individual specialty items concerning nursing homes, inpatient and outpatient hospitals, recipient management, recipient fraud, provider fraud and abuse, systems management and recoupment aspects of abusive practices.

Further information requests can be directed to:

Marianne Seddon, Manager
Surveillance and Utilization Review
Bureau of Medical Services
1575 Sherman Street, Room 914
Denver, Colorado 80203

Medicaid Information and Assistance Project (MIAP)

a project of the American Public Welfare Association

MIAP BULLETIN

No. 2
June 1985

FEDERAL REGISTER HIGHLIGHTS

Medicare and Medicaid Program: Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments; 42 CFR Parts 400, 405, 447.
Final Rule; May 10, 1985

This final rule broadens the statutory authority through which HCFA may withhold Federal payments in order to recover Medicaid or Medicare overpayments.

Under new section 1914 of the Social Security Act, federal financial participation in state Medicaid expenditures may be withheld to recover Medicare overpayments from: (1) an institution that has a Medicare provider agreement in effect but participates in the Medicare program at such a minimal level to prevent overpayment recovery; (2) an institution that no longer has a Medicare provider agreement in effect; and (3) a Medicaid provider that has previously accepted assignment under Medicare but has submitted no claims or has submitted claims less than the overpayment amount. This new provision extends the withholding authority to include not only institutions but physicians and suppliers of services as well.

Under new section 1885 of the Social Security Act, Medicare payments, under both Part A and B, may be withheld to recover Medicaid overpayments under the following conditions: (1) the institution has in effect a provider agreement under section 1886 of the Act or the physician/supplier has accepted assignment under section 1842(b)(3)(B)(ii) of the Act; and (2) the provider(s) described in (1) above has or previously had in effect an agreement with a state agency to furnish Medicaid services; and (3) the Medicaid agency has been unable to recover overpayments made to the provider.

Claims Processing Assessment System; 42 CFR Part 431
Final Rule; May 29, 1985

These final regulations, which are effective June 28, 1985, provide that existing Medicaid quality control claims processing requirements are replaced by a claims processing assessment system referred to as CPAS. CPAS is required both for states

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with an approved Medicaid Management Information System (MMIS) and for those without such a system. For states with an approved MMIS, CPAS and its requirements become an additional condition for approval/reapproval of MMIS. For states without an approved MMIS, CPAS is a State Plan requirement.

Effective 90 days after the effective date of this regulation all states must implement a CPAS that:

- Identifies deficiencies in claims processing operations;
- Measures the cost of deficiencies;
- Provides data to determine appropriate corrective action;
- Provides an assessment of the state's claims processing or that of its fiscal agent;
- Provides for a claim-by-claim review where justifiable by data; and
- Provides an audit trail that can be reviewed by HCFA or an outside auditor.

Two types of CPAS may be implemented by a state - the alternate CPAS and the mandatory/superior CPAS - and the type required for each state is determined from data obtained through the MMIS Systems Performance Review (SPR) and the Medicaid Quality Control (MQC) reviews. These reviews determine whether a state system satisfies the functional requirements and statistical levels of output relating to the accuracy, timeliness and integrity of claims processing systems in a state Medicaid operation.

States with demonstrated superior performance (i.e. below the payment error rate), as established by the above reviews, may establish an "alternate" CPAS. States using the "alternate" CPAS, whether performed in-house or by an outside contractor, may design and develop a system tailored to meet their individual needs subject to HCFA approval and operating within the CPAS guidelines as stated above.

States with demonstrated high error rates or MMIS states whose claims processing system is vulnerable to error must operate a "mandatory" or "superior" CPAS. A state with a system "vulnerable to error" may be one that: replaces its approved claims processing system and must meet initial MMIS approval conditions; changes its fiscal agent; or, one undergoing extensive changes that renders it vulnerable to increased error and incorrect payment. The "mandatory" CPAS must meet the CPAS guidelines as stated above and, in addition, the scope of review process documentation, development and reporting requirements are more comprehensive than the "alternate" system. Details regarding the "mandatory" CPAS will be fully described in the State Medicaid Manual (SMM).

A state required to operate the mandatory CPAS must use the system to be described in the SMM or a "superior" system, subject to HCFA approval, which would provide more data or comparable data at greater efficiency or economy.

This regulation does not remove the requirement that states perform Third Party Liability (TPL) quality control reviews as previously proposed in the August 9, 1983 notice of proposed rulemaking.

Imposition of Cost Sharing Charges Under Medicaid; 42 CFR Parts 431 and 447
Final Rule; May 30, 1985

This final rule sets forth the requirements regarding the imposition of cost sharing charges for medical services covered by Medicaid as revised by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Under section 1916 of the Social Security Act, states may impose cost sharing requirements on most services to both categorically and medically needy recipients with the following exceptions: (1) individuals who are under age 18; (2) institutionalized individuals; (3) pregnant women for services related to pregnancy; (4) recipients of emergency and family planning services; and (5) categorically needy individuals receiving services from an HMO. TEFRA also provided that the requirement that cost sharing amounts be nominal can be waived and a state may charge up to twice the maximum nominal amount for nonemergency services furnished by a hospital emergency room, if nonemergency outpatient facilities are also available.

Adjustment of Federal Share for Uncashed or Cancelled (Voided) Checks; 42 CFR Part 430 and 45 CFR Part 201
Proposed Rule; May 31, 1985

The proposed rule establishes a requirement for states to credit the Federal government for its portion of Medicaid checks which remain uncashed 180 days after the date of issuance. The rule also would require states to refund, on a quarterly basis, the Federal share of cancelled (voided) checks.

COURT CASES

Issue: **Prior notice of recipient's personal injury award**
Pennsylvania Superior Court No. 3547, Philadelphia 1982, March 1, 1985

The Pennsylvania Medicaid agency is entitled to receive prior notice of a recipient's personal injury settlement

or award so the agency may impose a lien for reimbursement for public assistance payments made on that recipient's behalf.

ISSUE: **Eligibility criterion - nonresidential property**
Pennsylvania Commonwealth Court No. 1507 C.D. 1982, March 27, 1985

The decision upholds the Pennsylvania Medicaid agency's interpretation of its Medicaid eligibility criterion which limits exemptions for income producing nonresidential property to those properties which are producing income during the projected benefit period. Nonresidential property not producing income is appropriately counted as a resource in the eligibility determination.

Issue: **Resource spenddown**
Massachusetts Supreme Judicial Court, 394 Mass. 466, April 9, 1985
Massachusetts Supreme Judicial Court, 394 Mass. 479, April 9, 1985

Although application of a resource spenddown is neither required nor precluded according to Federal statute, the court found that the Massachusetts Medicaid agency must utilize a resource spenddown in determining eligibility for Medicaid in order to comply with state law.

Issue: **Prior approval by a case manager**
Florida District Court of Appeals, First District No. BA-62, April 23, 1985

Upholds the validity of Florida's proposed regulation requiring prior approval by a case manager for non-emergency services for certain recipients.

Issue: **ICFs classified as IMDs**
U.S. Supreme Court No. 83-2136, May 20, 1985.
Connecticut Department of Income Maintenance v. Heckler, Secretary of Health and Human Services, et al.

The Supreme Court has upheld a Court of Appeals ruling that an Intermediate Care facility (ICF) may be classified as an institution for mental diseases (IMD) and, as such, any services provided to Medicaid recipients between the ages of 21 and 65 in an ICF which is classified as an IMD will not be covered by the Medicaid program. Title XIX specifically excludes

coverage for services provided to recipients between the ages of 21 and 65 in an IMD and the Secretary of Health and Human Services (HHS) has defined an IMD as "an institution primarily engaged in providing diagnosis, treatment or care of persons with mental diseases". Whether an institution is an IMD is determined by the "overall character" of the facility whether or not it is licensed as an IMD.

The Secretary of HHS has developed a number of criteria designed to focus on what constitutes "primarily engaged" and "overall character". Criteria applied in the case of the Middletown Haven Rest Home in Connecticut included: that 50% of the patients have a disability in mental functioning; and, that the facility hires staff specialized in the care of the mentally ill.

The Court recognized Congressional intent that long-term care in mental institutions is a state responsibility for recipients between the ages of 21 and 65.

This case was the result of only one state challenge to HHS policy on the issue, but the ruling has significant implications for all states.

COMING EVENTS

"Challenges for Changing Times"
National Association for Welfare
Research and Statistics Workshop
July 21-24, 1985
The Cornhusker Hotel
Lincoln, Nebraska

The conference will present findings and information related to completed, in-progress and upcoming research activities in the social services field.

For further information, please contact:

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or
Pat Taft
National Association for Welfare
Research and Statistics
P.O. BOX 94804
Lincoln, Nebraska 68509
(402) 471-3121

"Automation in a Human Services Environment: Personal Computing to Mainframe"
The American Association of Public Welfare Information Systems Management (AAPW/ISM)
September 22-25, 1985
Wyndam Hotel
Austin, Texas

This year's conference agenda is designed to provide professional training and assistance to all persons working with human services information systems at both the state and local level. Because this summer's Medicaid Management Information Systems (MMIS) conference has been cancelled, the AAPW/ISM conference will be increasing the portion of its agenda devoted to MMIS issues. In addition, the Systems Technical Advisory Group (STAG) will be meeting in conjunction with the conference. While this conference does not replace the MMIS conference, attendance is worth considering for those who may have planned to participate in the cancelled MMIS conference.

For further information, please contact:

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Third Annual National Medicaid Home and Community-Based Services Waiver Conference
September 29 - October 2, 1985
Kallispell, Montana

The conference agenda, schedule and logistical details are currently under development. Further information will be forwarded by Montana's Department of Social and Rehabilitation Services and will appear in future issues of the MIAP Bulletin.

For further information, please contact:

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MIAP BULLETIN

No. 3
July 1985

FEDERAL REGISTER HIGHLIGHTS

No significant Medicaid-related Federal Register activity to report for the period since publication of the June 1985 issue of the Bulletin.

COURT CASES

ISSUE: **Sale of nursing home**
New York Supreme Court, Appellate Division, Third Judicial Department, No. 49136, May 2, 1985

Disallows the purchase price of a nursing home buy-out as an allowable cost for a Medicaid nursing home reimbursement rate as the transaction was a nonarm's length one between relatives and the purchaser did not acquire additional assets other than those previously owned and used by the business.

Issue: **Habilitation services**
U.S. Court of Appeals, Sixth Circuit, No. 84-3181, May 17, 1985

This decision reverses the Secretary of HHS ruling disapproving the proposed Ohio state plan amendment that would include coverage of "habilitation" services outside of an institutional setting. In the initial decision to disapprove, the Secretary concluded that most of the habilitative services proposed by Ohio would not be reimbursable under the Act as they are social and educational rather than "medical". The Court of Appeals decision, however, allows Ohio to demonstrate that the services which it proposes to provide at habilitation centers fall within "medical assistance" as defined in Title XIX. If, after such effort by Ohio, the Secretary determines that the services were not covered by the definition of medical assistance prior to the 1981 amendment, but do qualify as "associated services" under the amendment, then Ohio must be given an opportunity to provide them under a home and community-based services waiver.

Issue: **Federal share of overpayments**
U.S. Court of Appeals, Second Circuit, No. 84-6332, May 20, 1985

This case finds that HHS may recoup the federal share of over-payments made under the New York Medicaid program's interim payment system prior to the state agency's recovery of these overpayments from the providers.

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GRANT APPEALS BOARD DECISIONS

Beginning in this month's issue, the MIAP Bulletin will report on major Medicaid-related Grant Appeals Board decisions. In this issue, MIAP staff has summarized the most significant of these decisions from March 1, 1985 to the present.

Issue: **Disallowance for state overpayments not yet collected**
Iowa Department of Human Services, Decision No. 629, March 18, 1985; and
Ohio Department of Public Welfare, Decision No. 637, April 2,1985; and
Washington Department of Social and Health Services, Decision No. 645, April 30, 1985; and
Minnesota Department of Human Services, Decision No. 653, June 7, 1985.

The board determined that, under section 1903 (d)(2) of the Social Security Act, HCFA may require states to return the federal share of firmly established overpayments* to Medicaid providers regardless of whether the state has or ever will collect these amounts from the providers. The board also determined that the difference between interim and (lower) final nursing home rates** are overpayments subject to adjustment by HCFA, rather than medical assistance payments to be adjusted under section 1903 (d)(3) only when recovered by the state from the provider, as the state had maintained in its brief.

Issue: **Disallowance of funds which the state sought to retain on behalf of itself and county social service agencies, from third party liability collections.**
New York State Department of Social Services, Decision No. 628, March 19, 1985

The state sought to retain 15% of certain sums collected from third parties which it credited to certain county social service agencies for collection efforts the state initiated on the counties' behalf. This action was taken per a cooperative agreement with the counties for the state to act as an agent for the counties in certain third party resource recoveries.

The board upheld a disallowance of certain of these incentive payments on the following basis: (1) the applicable legislation is meant to encourage agencies the state does not control to

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*This includes overpayments as specified in the above paragraph, as well as overpayments uncovered by the state's SURs and errors committed by the provider or the state in processing claims.

**This would also apply to differences between interim and (lower) final rates for hospital services.

pursue debts offsetting Medicaid expenditures, not to pay the state for exercising its previously established enforcement and collection responsibilities while it gives local agencies an "incentive" payment for agreeing to have the state do so; (2) incentive payments pertain only to the direct pursuit of assigned individual rights to support and payment for medical care (i.e. not any type of third party resources), and to both enforcement and collection (i.e. not just routine collection); and (3) a state cannot claim an incentive payment for sums recovered from Medicare collection efforts.

Issue: **Disallowance for day school programs provided by the State Department of Education to residents of intermediate care facilities for the mentally retarded (ICFs/MR)**
Massachusetts Department of Public Welfare, Decision No. 638, March 29, 1985

HCFA disallowed funds for day school programs provided by the State Department of Education to residents of ICFs/MR because federal regulations prohibit payment for "vocational training and educational activities" for individuals in ICFs/MR.

The board upheld HCFA's disallowance and stated the following points to refute the state's arguments: (1) the bar on Medicaid funding for vocational training and educational activities for individuals in ICFs/MR does not apply only in those cases where states have already been reimbursed from some other federal source; (2) the services provided do not qualify as "special education or related services" which are fundable under Medicaid as habilitative activities; and (3) that simply because the services are part of an active treatment plan per program regulations, this does not mean that the bar on payment for educational activities under Medicaid does not apply.

Issue **Disallowance for expenses claimed at 75% federal financial participation (FFP) for support staff to skilled professional medical personnel (SPMP) and MMIS personnel**
California Department of Health Services, Decision No. 646, May 7, 1985

The board upheld HCFA's disallowance maintaining that the state has the burden to provide sufficient documentation to justify its claim for enhanced (75%) FFP and it could not document that the support staff which worked on routine claims review had any direct relationship to SPMP, nor that other support staff had worked on an approved MMIS during the period in question. Therefore, the board ruled, there was no basis for enhanced FFP.

Issue: **Disallowance based upon indirect costs allocated to the state's Medicaid Management Information System (MMIS) at 75% Federal Financial Participation (FFP)**
New Jersey Department of Human Services, Decision No. 648, May 17, 1985

HCFA disallowed funds to the state and disapproved the portion of its revised Cost Allocation Plan (CAP) that provided for 75% FFP for statewide and department-wide indirect costs allocated to the state's MMIS. HCFA took this action on the basis of a February 1982 Action Transmittal (AT) of the State Manual which stated that indirect costs not "directly attributable" to the MMIS cost center, such as personnel, finance, etc., will be funded at 50%.

The board reversed the HCFA disallowance stating that there was no basis in policy for a distinction between indirect costs "directly attributable" (75% FFP) to the operation of MMIS and those only "attributable" (50% FFP) to the operation of MMIS. The 1982 AT stated its purpose was to "clarify policy already stated" in Part II of the State Manual, but in fact the language of the applicable statute, the applicable section of the State Manual, and previous ATs provide no such basis for distinguishing between types of indirect costs. Therefore, a "clarification" cannot be used to advance a more restrictive policy than previously promulgated.

Issue: **Disallowance for failure to conduct an annual review of each patient in an Intermediate Care Facility (ICF)**
South Dakota Department of Social Services, Decision No. 650, May 28, 1985

HCFA took a disallowance because it alleged that the state failed to include one Medicaid patient in its annual review of a particular ICF. This patient was determined to be eligible for Medicaid after the state's annual review of the facility had begun and so the state was not aware at the time of its review that the patient was Medicaid eligible. HCFA maintained that any patient who was Medicaid eligible at the time of the review must be included in the review notwithstanding the state's difficulty in learning of new eligibles during the course of its review.

The board reversed HCFA's decision stating that an individual who has not been determined eligible for Medicaid as of the first day that a facility is reviewed is not a patient within the meaning of section 1903 (g)(1)(D) of the Social Security Act and need not be included in the review.

Issue: **Disallowance for failure to meet medical review requirements for Intermediate Care Facilities (ICFs)**
Missouri Department of Social Services, Decision No 658, June 7, 1985

Originally HCFA made a disallowance based upon a failure to meet medical review requirements in two ICFs. During the appeal, the

state documented to HCFA's satisfaction that it met the review requirements for all but one quarter in one facility. The issue then became whether the calculation of the reduction reimbursement for ICF services should exclude the costs of services in ICFs/MR (mentally retarded).

The state maintained that ICF/MR costs should not be included in the reduction calculation because these services differ significantly from general ICF services and because ICF/MR services were not the subject of HCFA's review (among other arguments).

The board upheld the HCFA-calculated disallowance stating that neither the Social Security Act nor the regulations differentiate between ICF and ICF/MR with regard to level of care and that HCFA is not required to include ICFs/MR in every review of ICFs.

Issue: **Utilization control disallowances and the effect of DEFRA Amendments**, Decision No. 655, June 7, 1985

Eight states* appealed disallowances taken by HCFA to disallow funding for long-stay inpatient services** provided by institutions in calendar quarters ending September 30, 1983 through September 30, 1984. This funding was disallowed because, according to HCFA, the states failed to make a satisfactory showing that they had effective programs of utilization control. The showing had to include evidence that the patient's need for services was being certified and recertified in a timely manner and that each patient had a plan of care.

The states argued that HCFA lacked authority to make these disallowances because of amendments to the Social Security Act made by the Deficit Reduction Act of 1984 (DEFRA), which eliminated the provisions requiring states' showing to include evidence of certifications, recertifications, and plans of care.

The board upheld the disallowances by HCFA concluding that disallowances taken for services provided in quarters prior to July 1, 1984 are not precluded by the DEFRA amendments.

Issue: **Disallowances for failure to meet the utilization control requirements for long-stay services in ICFs**
Virginia Department of Health, Decision No. 660, June 19, 1985

HCFA disallowed funds because it found that the state did not have an effective program for the control of utilization of long-stay

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*Arkansas, California, Indiana, Missouri, New Hampshire, Oklahoma, Virginia, Wyoming.

**This means services provided to a recipient after a total of 60 days of an inpatient stay in a hospital, skilled nursing facility or intermediate care facility (90 days in the case of a mental hospital) during a 12-month period beginning July 1, not counting days paid for by Medicare.

services* in ICFs, based upon violations of physician recertification and plan of care requirements.

The state maintained that it did have a system for the annual review of facilities which was approved by HCFA and which discovered the deficiencies in the ICFs, and thus the state should be considered to have an effective utilization control program.

The board upheld the HCFA disallowances, stating that the requirements for (1) annual on-site reviews (inspections of care) and (2) recertifications and plans of care are separate requirements and annual on-site reviews are not sufficient in and of themselves to show a satisfactory utilization control program.

Issue: Disallowance for failure to meet the utilization control requirements for institutional long-term care services
State of Washington Department of Social Services, Decision No. 663, June 21, 1985

HCFA disallowed funds because it found the state lacking in an effective program for controlling utilization of long-term care services based upon state failure to perform annual reviews for each patient as required by section 1903 (g)(1)(D) of the Social Security Act.

The state maintained that it was in "substantial compliance" with utilization control requirements and that the "number of violations found in these facilities was de mininus".

The board upheld HCFA's disallowance stating that HCFA has no discretion to waive the reduction for even minor violations.

Issue: Disallowances for claims for Federal Financial Participation (FFP) for inpatient psychiatric services provided in institutions for mental diseases (IMDs).
Ohio Department of Human Services, Decision No. 659, June 18, 1985

Originally, Ohio was one of several states which appealed HCFA decisions disallowing claims for federal financial participation in per diem rates for inpatient psychiatric services provided by institutions for mental diseases to certain individuals during their partial months of admission and discharge. The Board upheld HCFA in a joint decision (Decision No 436, May 31, 1983), with the caveat that HCFA should reduce each disallowance to the extent that a state could prove that a part of its rate represented allowable costs of services separately covered in the states Medicaid Plan.

Following Decision No. 436, the states presented data to HCFA to show partial allowability of their claims. HCFA then determined that services "integral to inpatient psychiatric services" were not

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*See decision No. 655 above for definition.

fundable, even if covered under the Medicaid Plans. The states appealed, and the Board reversed HCFA in another joint decision, holding that services separately covered in a state plan were allowable under the partial month eligibility provisions in HCFA regulations, even if psychiatric in nature. (Decision No. 535, May 9, 1984.)

HCFA claimed that the states' per diem rate represented costs of nursing services, which were not separately covered under the states' Medicaid plan and thus were not allowable. Alternately, the state claimed that its services were part of "inpatient hospital services" and "physicians services" and as such should be considered as separately covered under the plan. The board determined that they are in fact nursing services, not "inpatient hospital services" or "physician services", and, as nursing services are not covered separately in the states' Medicaid plan, the board upheld HCFA's disallowance.

OF NOTE

OFFICE OF INSPECTOR GENERAL (IOG) REPORT: FRAUD AND ABUSE
"Report of a Study Under the Auspices of the President's Council on Integrity and Efficiency: Using the Computer Against Fraud and Abuse in Medicare and Medicaid" May 1985.

This report summarizes federal, state, and private health-related organizations' responses to a nationwide survey regarding health care program vulnerabilities to fraud and abuse. The survey assessment: (1) addresses the major vulnerability areas found in the detection and prevention of health care fraud and abuse, (2) documents the significant accomplishments of the responding entities in these areas, and (3) assesses, by organizational category, the future needs in efforts to curtail fraudulent and abusive activities in the health care sector.

In addition this report provides information on the Fraud and Abuse Clearinghouse for Effective Technology Sharing (FACETS) established by IOG at the National Professional Development Center in Atlanta, Georgia. The objectives of FACETS are to gather and disseminate information on computer applications in the fraud and abuse area and disseminiate and evaluate concepts for detecting fraud and abuse. Attached to this issue of the MIAP Bulletin is an information sheet on the Clearinghouse and a form which state Medicaid agencies can return to FACETS if they are interested in the activities of the Clearinghouse.

OF NOTE

OFFICE OF INSPECTOR GENERAL (OIG) AUDIT REPORT, NO. ACN 10-50201, MAY 22, 1985
"Credits to Medicaid Should Be Required Where State Pharmacy Policies and Procedures Permit the Return and Redispensing of Prescription Drugs"

This report finds that substantial savings can accrue to the Medicaid program if appropriate credits are made to Medicaid when drugs are returned and redispensed in states that allow such practices. In its recent audit of this practice, the OIG found that, of 32 states reviewed, 26 states permitted some reusable drugs to be returned to pharmacies but 7 of these states did not make credits to the Medicaid program. The OIG recommends HCFA strengthen Medicaid regulations to require that, where state pharmacy policies permit the return and redispensing of drugs, provisions be made for appropriate credits to Medicaid.

STATE EXCHANGE

Subject: **State Medicaid Directors' Association**

For your information and reference, included with this issue of the MIAP Bulletin is the Summer 1985 membership list of the State Medicaid Directors' Association. Inquiries concerning the contents of this list may be directed to Richard Jensen, American Public Welfare Association, 1125 15th St., NW, Washington, D.C. 20005, (202) 293-7550.

COMING EVENTS

"Automation in a Human Services Environment: Personal Computing to Mainframe"
The American Association of Public Welfare Information Systems Management (AAPW/ISM)
September 22-25, 1985
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(202) 293-7550

Third Annual National Medicaid Home and Community-Based Services Waiver Conference
September 29 - October 2, 1985
Kalispell, Montana

The conference agenda, schedule and logistical details are being finalized and the specific workshop topics will appear in the August 1985 issue of the Bulletin. During the week of July 15, 1985, the first mailings will be sent to an extensive list of potential conference attendees, including state Medicaid agency staff. If you have not received any conference information by the end of July, please feel free to contact Dale Haefer at the address listed below.

For further information, please contact:

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MIAP BULLETIN

No. 4
August 1985

FEDERAL REGISTER HIGHLIGHTS

Medicare and Medicaid Programs; Deficit Reduction Act of 1984; Information Notice on Medicare and Medicaid Amendments.
General Notice; July 17, 1985

This notice describes briefly some of the provisions of Title III, Division B of the Deficit Reduction Act of 1984 (P.L. 98-369). According to the notice, these provisions are self-explanatory and so clear and explicit that regulations are not required for their implementation. To the extent that the new statutory provisions conflict with existing HCFA regulations, the provisions of the new law supersede. In addition, the provisions relating to Medicaid are self-implementing and states may adopt their own lawful interpretation of the new provisions, unless and until contrary regulations are adopted or different interpretations are issued.

Summarized briefly are those provisions having some impact on the Medicaid program:

(1) Section 2302* - Medicare Part B premium

Extends the existing temporary provision, which sets the monthly premium paid by enrollees at an amount equal to 25% of the SMI (Part B) program costs for aged beneficiaries through calendar years 1986 and 1987.

(2) Section 2303 - Clinical diagnostic laboratory services payment

Requires establishment of a fee schedule for Part B laboratory services (except those furnished by a hospital or SNF for its in-patients) furnished on or after July 1, 1984. For independent clinical laboratories and lab services in a physician's office, the fee schedule is to be established at 60% of the prevailing charge for the 12 month period beginning July 1, 1985; for hospital-based laboratory

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* section numbers refer to provisions of the Deficit Reduction Act of 1984

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services furnished to out-patients, the fee schedule is set at 62% of the prevailing charges. This provision is applicable to the extent that a state paid more for a lab service than would be paid under the Medicare schedule.

(3) Section 2306 - Limitation of physicians' fee charge levels

Limits Medicare customary and prevailing charges for physicians' services for a 15 month period beginning on July 1, 1984 to the level in effect for the period July 1983 - June 1984.

This section also establishes the concept of participating suppliers - suppliers who agree to enter into an agreement to accept assignment for all their Medicare claims during 12 month periods.

(4) Section 2314 - Revaluation of assets

Limits the increase in capital-related cost reimbursement to a new owner that would result from the revaluation of hospital or SNF assets on or after July 18, 1984 to the lesser of (a) historical costs or (2) the acquisition cost of the assets to the new owner. States, in determining Medicaid reimbursement rates for hospitals, ICFs and SNFs with a change of ownership, are required to assure that the methodologies used to establish rates do not increase the rates more than they would increase under Medicare policy.

(5) Section 2331 - Research and Demonstration Projects

Removes the restriction excluding the Secretary from entering into R&D projects with for-profit organizations.

(6) Section 2335 - Tuberculosis treatment requirements

Repeats special conditions applicable to coverage under Medicare and Medicaid of services provided by institutions primarily providing tuberculosis diagnosis and treatment.

(7) Section 2338 - Working Aged

Establishes a special Medicare Part B enrollment period for workers 65-69 who elect an employer group health plan as the primary payer for medical services. Also specifies when Part B coverage begins under various circumstances.

(8) Section 2340 - Psychiatric Hospitals

Repeals the statutory requirements that psychiatric hospitals and distinct psychiatric units be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) in order to participate in Medicare and Medicaid. Does not repeal the existing conditions applicable to hospitals.

(9) Section 2361 - Medicaid coverage for pregnant women and children

Requires states to provide Medicaid coverage to: (1) any qualified pregnant woman who (a) would be eligible for AFDC if the child had been born and living with her in the month of payment; or (b) is a member of a family that would be eligible for AFDC if the state's AFDC plan included an unemployed parents' program; and (2) qualified children under age 5 who were born after September 30, 1983, and meet income and resource requirements under a state's approved AFDC plan.

(10) Section 2365 - Raises the annual ceiling of Federal matching payments for Medicaid services to: Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands and American Samoa.

Medicaid Management Information Systems (MMISs); 42 CFR Parts 400 and 433
Final Rule; July 30, 1985

The final rules provide additional requirements regarding the conditions and procedures for initial approval and reapproval of MMISs, as well as the procedures for reductions in federal financial participation in state administrative expenditures for failure to meet these requirements.

COURT CASES

Issue: **Validity of agency regulations defining Skilled Nursing Facility (SNF) care**
Pennsylvania Commonwealth Court, April 26, 1985

The court held that a hearing officer's decision to uphold the validity of agency regulations creating a new classification system to determine Medicaid eligibility for skilled nursing and intermediate care, was supported by substantial evidence. The

agency regulations were revised to bring them into conformance with federal regulations and prevent physicians from qualifying patients for skilled care who met the agency's regulations, but could not meet the federal regulations. The court stated that the agency's interpretation of its regulations must be given controlling weight unless (1) that interpretation is plainly erroneous or inconsistent with the regulations or (2) the regulations are inconsistent with the underlying legislative scheme.

Issue: Automatic termination of Medicaid eligibility based on loss of AFDC eligibility
California Court of Appeals, Second District, Third Division, May 7, 1985. 167 Cal. App. 3d 1070.

The court ruled that California's policy of automatically terminating Medi-Cal benefits for individuals whose AFDC coverage has ended, without determining whether those individuals qualify for Medi-Cal under other nonautomatic Medi-Cal categories, violates federal Medicaid rules requiring prompt determination of each individual's Medicaid eligibility. Accordingly, the court held that the state is required to continue payment of Medi-Cal benefits to terminated AFDC recipients pending the state's determination of the recipient's eligibility for Medi-Cal benefits under other, noncategorical, eligibility categories.

Issue: Use of provider records in a criminal proceeding
Pennsylvania Superior Court, No. 2513 Philadelphia 1983, May 31, 1985

A state agency investigator has no duty to inform a provider of any constitutional rights against self-incrimination when inspecting the provider's books and records during the course of a review of the provider's practice and billings when no criminal prosecution was pending at the time of the review.

Issue: Recovery of funds erroneously paid by the state Medicaid agency
Minnesota Supreme Court, No. C9-84-295, June 7, 1985

A physician erroneously reimbursed for non-covered Medicaid services must repay the state Medicaid agency regardless of the state's initial error in making the payment and regardless of the fact that the physician no longer participates in the Medicaid program.

Issue: **Medicaid eligibility for Aliens Residing in the U.S. Under Color of Law**
Massachusetts Supreme Judicial Court, June 10, 1985. 395 Mass. 107

This case addresses several issues dealing with a nonimmigrant alien's eligibility for public medical assistance. The court vacated the Massachusetts regulation (106 Code Mass. Reg. 503.200) prohibiting aliens without permanent resident status from receiving medical assistance as it was in conflict with a superseding federal regulation (42 CFR 435.402) which states, in part, "the state agency must provide Medicaid to otherwise eligible residents of the United States who are (a) citizens; or (b) aliens lawfully admitted for permanent residence or **permanently residing in the United States under color of law."**

In this specific case, the applicant for Medicaid is not a permanent resident but may be eligible for Medicaid under the "color of law" provision. The term "under color of law" is not specifically defined in any Supreme Court decisions but in lower courts has been interpreted to include cases that, in strict terms, are outside the law but are near the border. The court remanded this case back to the Massachusetts Department of Public Welfare for development and consideration of further evidence to determine if the "under color of law" provision should be appropriately applied.

Issue: **HHS Plan of Compliance regarding quality of care in nursing homes**
U.S. District Court, District of Colorado. RE: Civil Action No. 75-M-539, Plan filed June 10, 1985

Per Order of the Court, the Secretary of HHS has filed a plan to "promulgate regulations which will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care." The Secretary intends both to implement new survey procedures and forms and propose revisions to regulations to implement these changes. Between October 31, 1985 and December 31, 1985, the new survey process will be developed, revised and approved; in January 1986, the new procedures will be implemented, and between January and August, 1986, the final regulations will be developed and published.

GRANT APPEALS BOARD DECISIONS

Issue: **Disallowance of enhanced Federal Financial Participation (FFP) at 90% for abortion services for family planning purposes**
California Department of Health Services, Decision No. 665, June 28, 1985

At issue in this case is whether adequate case documentation

exists to support FFP at 90% for family planning services, specifically abortions. Originally, the state erroneously submitted claims at 90% FFP for all abortions and related services performed during 1977 and 1978, regardless of whether these services were for family planning purposes. Abortion services performed for other than family planning reasons are only reimbursed at 50% FFP. Through a sampling process agreed to by all parties, all but 66 cases were adequately classified. This specific appeal addresses whether these 66 cases were documented as being family planning related and eligible for 90% FFP. Through a detailed review of all available documentation for each case, the board determined that 65 of the 66 cases were, in fact, for family planning purposes and overturned the disallowance for those cases. The cases were then incorporated into appropriate categories of the larger sample to extrapolate how much of the original disallowance should be overturned.

Issue: **Disallowance of enhanced FFP for family planning-related abortion services due to inadequate documentation**
California Department of Health, Decision No. 666, June 28, 1985

HCFA disallowed enhanced FFP (90%) for all abortion services claimed by the state for the period 1972-77 since the state did not differentiate which cases were for family planning services (eligible for 90% FFP) and which cases were not (eligible for only 50% FFP). The state's error was not discovered until a 1980 HCFA audit. The state argued that it should not be subject to a disallowance based on lack of documentation because of the expiration of the three-year period for retaining records. HCFA disagreed, asserting that the burden of proof lay with the state to document its claim for enhanced FFP. The board concluded that, although the burden of proof is, in fact, on the state, the findings of GAB Decision No. 665, where 82% of the aggregate abortion services were determined to be family planning-related, could be applied in this case. Hence, based on data from GAB Decision No. 665, the board overturned the disallowance of enhanced FFP for 82% of the cases in question and upheld the remaining disallowance.

Issue: **Disallowance for the cost of drugs determined to be ineffective by the Federal Drug Administration (FDA)**
Illinois Department of Public Aid, Decision No. 667, July 2, 1985

HCFA disallowed payment for three drugs on the basis that they were determined to be ineffective by the FDA. The state did not dispute this position but maintained that HCFA did not give the state adequate notice to terminate use of the drugs. The board upheld the disallowance relative to two of the drugs, stating that the controlling factor was the HCFA policy that the

states would have 30 days from the date a notice is published in the Federal Register by FDA to terminate use of drugs so specified in such notice (based on provisions of section 2103 of OBRA/P.L. 97-35).

In the case of the third drug, which was determined to be ineffective prior to passage of OBRA, HCFA had promised the states to publish in the Federal Register a list of all drugs which had been determined to be ineffective prior to the date of the HCFA regulations (based on OBRA provisions) and, moreover, allow a 90-day grace period for state implementation. The board determined the state did meet the controlling deadlines in this case and reversed the HCFA determination and disallowance.

Issue: Disallowance due to failure to operate an effective program of utilization control in Intermediate Care Facilities (ICFs)
New Hampshire Department of Health and Welfare, Decision No. 669, July 3, 1985

HCFA alleged that the state's recertifications of the appropriate level of care were untimely. The state argued that the Deficit Reduction Act of 1984 (DEFRA) allows for a 10-day grace period in which recertification may be performed. The board upheld HCFA's disallowance stating that to apply the grace period in this instance would be to apply it retroactively, and, that at any rate, the state had not shown good cause for the delay in recertification as DEFRA requires.

Issue: Disallowance based on the failure to operate an effective program of utilization control in Intermediate Care Facilities (ICFs)
Missouri Department of Social Services, Decision No. 670, July 10, 1985

The board upheld HCFA's disallowance based upon state violations of requirements for timely and valid physician's certifications and recertifications of plans of care. While the state documented that a physician had completed progress notes and/or physician's orders on a number of patients, the board ruled that such documentation does not necessarily attest to the patient's need for ICF level of care, since such need was not so specified. In addition, physician's order forms which were inappropriately marked "private" for several Medicaid patients led the board to believe that the physician may, in fact, not even have known that the patient was a recipient of Medicaid for whom recertification of care was needed.

Issue: Disallowance based upon the failure to operate an effective program of utilization control in Skilled Nursing Facilities (SNFs)
Arkansas Department of Human Services, Decision No. 671, July 10, 1985

HCFA alleged that the state's recertifications of the appropriate level of care were untimely in several facilities. Although the state challenged HCFA's authority to impose a disallowance in light of section 2363 of DEFRA, the board upheld that portion of the disallowance where the state was found to be untimely in its certifications on the basis that the violations took place prior to the effective date of DEFRA.

HCFA also alleged that certain recertifications were invalid because the dates accompanying the recertifying physician's signature were typed or handwritten in a different color ink than the signature. The board reversed HCFA's decision and disallowances in these cases stating that dates written in a different ink were not, per se, proof of invalid recertification and noted that HCFA did not allege that recertification dates were altered or recertifications were not performed on the correct date.

Issue: Disallowance based on the failure to operate an effective program of utilization control in Intermediate Care Facilities (ICFs)
Oklahoma Department of Human Services, Decision No. 672, July 19, 1985

HCFA alleged that certain recertifications of the need for ICF care were invalid because they were signed by someone other than the attending physician. The board upheld the HCFA determination and disallowance in this case, stating that only a physician may fulfill the recertification requirement. HCFA also alleged that certain recertifications were invalid because the dates accompanying the physician's signature were either stamped or written by someone other than the physician. The board reversed the HCFA determination and disallowance in this case, stating that because the physician may not have personally dated the recertification document does not, in and of itself, invalidate the recertification.

OF NOTE

"Inspector General's Semi-Annual Report on Fraud, Abuse and Waste", October 1, 1984 - March 31, 1985 (Medicare and Medicaid)

In its semi-annual report, the Office of the Inspector General (OIG) reported on the findings of its reviews conducted during

the first 6 months of FY85. The report identified four areas of legislative and regulatory reform which could result in savings, in addition to recommendations for more efficient program administration. The efforts of the OIG in combination with state Medicaid Fraud Control Units resulted in $11.6 million in financial recoveries and savings, 245 Medicaid or Medicare fraud convictions and the barring of 110 practitioners from participation in Medicare and Medicaid programs.

Copies may be obtained from:

Office of the Inspector General
Public Affairs Office
5640 HHS Building
330 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 472-3142

"Medicaid Coverage and Payment Policies for Organ Transplants: A Fifty State Review", Intergovernmental Health Policy Project (IHPP)/HCFA, July, 1985.

This report contains the findings of a survey conducted by IHPP, in conjunction with HCFA, regarding the 50 states' Medicaid policies on organ transplantation. It includes topics such as coverage of transplants, costs, Medicaid payment methods and transplant criteria.

For further information, please contact:

Dick Merritt
Intergovernmental Health Policy Project
2100 Pennsylvania Avenue, Suite 616
Washington, D.C. 20037
(202) 872-1445

"Intergovernmental Options for Reducing Infant Mortality: Conference Proceedings September 13-15, 1984", Intergovernmental Health Policy Project (IHPP)

The report includes the proceedings of a conference convened by IHPP with support from the United States Public Health Service for the purposes of (1) providing a forum for participants to discuss their programs for improving maternal and infant health and sharing their successes and failures; (2) enabling federal, state and local government representatives to explore ways to more effectively coordinate their efforts to reduce infant mortality and morbidity; and (3) promoting dialogue between the

various levels of government and private organizations.

For further information, please contact:

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Intergovernmental Health Policy Project
2100 Pennsylvania Avenue, Suite 616
Washington, D.C. 20037
(202) 872-1445

COMING EVENTS

"Automation in a Human Services Environment: Personal Computing to Mainframe"
The American Association of Public Welfare Information Systems Management (AAPW/ISM)
September 22-25, 1985
Wyndam Hotel
Austin, Texas

This year's conference agenda is designed to provide professional training and assistance to all persons working with human services information systems at both the state and local level. Because this summer's Medicaid Management Information Systems (MMIS) conference has been cancelled, the AAPW/ISM conference will be increasing the portion of its agenda devoted to MMIS issues. In addition, the Systems Technical Advisory Group (STAG) will be meeting in conjunction with the conference. While this conference does not replace the MMIS conference, attendance is worth considering for those who may have planned to participate in the cancelled MMIS conference.

For further information, please contact:

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Third Annual National Medicaid Home and Community-Based Services Waiver Conference
September 29 - October 2, 1985
Kalispell, Montana

The conference agenda, schedule and logistical details are being finalized and the specific workshop topics will appear in a future issue of the Bulletin. During the week of July 15, 1985,

the first mailings were sent to an extensive list of potential conference attendees, including state Medicaid agency staff. If you have not received any conference information by the end of July, please feel free to contact Dale Haefer at the address listed below.

For further information, please contact:

Dale Haefer
Department of Social and
Rehabilitation Services
P.O. Box 4210
Helena, Montana 59604
(406) 444-4540

HMO Medicaid Update II
October 15, 1985
Park Terrace Airport Hilton
St. Louis, Missouri

Sponsored by the Group Health Foundation, an educational affiliate of the Group Health Association of America (GHAA). This conference will examine the latest federal and state Medicaid contracting innovations and their impact on prepaid delivery systems. It is the second program in a series designed to provide an intensive one-day review of issues affecting prepaid health care nationwide.

Issues to be explored at this session are:

- o state contracting with consortiums of urban and rural medical care providers;
- o mandatory enrollment of Medicaid recipients in HMOs;
- o Health Insuring Organizations (HIOs); and,
- o the impact of growing Medicaid enrollment on HMO operations.

For further information, please contact:

Conference Office
Group Health Foundation
624 Ninth Street, N.W.
Washington, D.C. 20001
(202) 737-4311

The MIAP Bulletin is published monthly by the Medicaid Information and Assistance Project (MIAP) of the American Public Welfare Association, 1125 Fifteenth St., N.W., Washington, DC, 20005, (202) 293-7550. Circulation is limited.

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MIAP BULLETIN

No. 5
September 1985

FEDERAL REGISTER HIGHLIGHTS

No significant Medicaid-related Federal Register activity to report for the period since publication of the August 1985 issue of the Bulletin.

COURT CASES

Issue: Payment in Full for Physician Services
California Superior Court, Appellate Department, Los Angeles County, March 5, 1985. 167. Cal. App. 3d Supp. 11.

California, in its Medi-Cal program, has adopted a regulation that limits participation in its program to providers who accept, as payment in full, the amount paid by the state for a particular service. In this case, since the provider consented to accept the patient as a Medicare patient and subsequently submitted a crossover claim to Medi-Cal on her behalf, the provider is not entitled to bill the patient for any remaining balance of his fee. The physician's acceptenace of a Medi-Cal authorization to file a claim on the patient's behalf invalidates a prior agreement between the patient's daughter and physician to recover the the balance of his fee if not fully reimbursed by Medicare or Medi-Cal.

Issue: Conditions of Eligibility - Medically Needy
Massachusetts Supreme Judicial Court, June 12, 1985. 395 Mass. 189.

The court addresses two issues concerning medical assistance eligibility for the medically needy: income disregards and budget periods for spend down. In the first issue, the Massachusetts policy of applying a flat $75.00 income disregard when determining medical assistance eligibility for the medically needy, regardless of the actual taxes, etc. withheld from income, is upheld. In making its decision, the court cited that the $75.00 disregrd was comparably applied in determining eligibility for AFDC cash assistance recipients.

The court, however, found that the application of a 6 month budget period (for spend down purposes) for medically needy applicants violated the "comparability of income eligibility" determination as AFDC cash assistance applicants were only

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subject to a one month budget period for the purposes of income eligibility.

Issue: **Federal Court Jurisdiction in a Reimbursement Rate Appeal**
U.S. District Court, District of Connecticut. No. H-84-1065(TEC), June 13, 1985

The federal courts do not have jurisdiction to hear a suit brought by a provider questioning the validity of the Connecticut's Medicaid agency determination of a nursing home reimbursement rate. The court determined in this case that the Eleventh Amendment prohibits a claimant from bringing suit in a federal district court against state officials where the relief would have an effect on the treasury. Furthermore, evidence indicated that the provider had not availed itself of the state appeal process for such disputes.

Issue: **Disclosure of Provider Patient Records for a Fraud Investigation**
Massachusetts Supreme Judicial Court, July 2, 1985. 395 Mass. 284

The court determined that the Massachusetts Medicaid agency may request a psychiatrist's patient records be submitted to a grand jury as part of a Medicaid fraud investigation of that provider. However, the agency may only have access to those parts of the records which establish which patients were seen, the number of patient visits and the length of each visit. The portion of each patient's record related to the substance of psychotheraputic dialogue, the patient's thoughts and emotions as well as descriptions of conduct that may be embarrassing are barred from review by the state agency and grand jury.

Issue: **Continuation and Conversion Benefits for Medicaid Recipients Enrolled in Health Maintenance Organizations (HMOs)**
Wisconsin Attorney General Opinion, No. OAG 27-85, July 3, 1985

This opinion confirms that HMOs which contract with the Wisconsin Department of Health and Social Services to provide coverage to medical assistance recipients are required to offer continuation benefits to those whose eligibility for medical assistance terminates pursuant to Wisconsin Statute Sec. 632.897(1). However, the Office of the Commissioner of Insurance may exempt an HMO from this provision if the plan "provides innovative approaches to the delivery of health care or which are designed to contain health care costs, and which cannot operate successfully" if required to meet this provision (Sec. 628.36(2m)(b) and (3)).

Issue: Physician's Permanent Disqualification from Program Participation
New York Supreme Court, Appellate Division, Third Judicial Department. No. 49015, July 11, 1985.

The court upheld the state's decision to permanently bar a physician from participation in the state's Medicaid program for failure to maintain adequate patient records. The physician was found to be rubberstamping progress notes which gave no information on patients' condition, symptoms or therapy plans.

Issue: Interest Expense - Nursing Home and Related Company
Pennsylvania Commonwealth Court. No. 2549 C.D. 1983, July 16, 1985.

A nursing home appropriately deducted interest paid to a "related" company from its total "other interest" expense report line item as a nonallowable cost. However, the Pennsylvania Department of Public Welfare was found to have erroneously offset this same interest expense amount against the nursing home's interest on capital indebtedness. The court determined that the interest paid to a related company is not income but an expense.

GRANT APPEALS BOARD DECISIONS

Issue: Incentive Payments for Third Party Liability Collections
New York State Department of Social Services, Decision No. 673, July 19, 1985.

The board upheld a disallowance of $47,587 based on the fact that the claim for incentive payments for funds recovered under state programs and activities cannot be made if these programs are funded entirely by non-federal dollars.

Issue: Disallowance for Failure to Meet Utiliztion Control Requirements in Intermediate Care Facilities (ICFs)
Tennessee Department of Health and Environment, Decision No. 674, July 22, 1985

HCFA disallowed funds of $182,755.86 for Tennessee's failure to operate an effective program of utilization control at four intermediate care facilities (ICFs). HCFA alleged that physicians in these facilities failed to recertify patients in a timely manner; that plans of care for certain patients were not updated in a timely way or were missing; and recertifications did not meet statutory-regulatory requirements. Tennessee, in a document submitted to the board, conceded the existence of at least one utilization control violation at each of the four facilities. The board upheld the disallowance.

Issue: Disallowance Due to Accounting Change in a State's Prospective Reimbursement System for Intermediate Care Facilities
Missouri Department of Social Services, Decision No. 676, July 31, 1985

Missouri appealed a disallowance by HCFA of $874,083 for claims for services from 5 intermediate care facilities (ICFs) for the period October 1, 1981 - June 30, 1983. The disallowed claims were computed under a prospective rate system and incorporated a change in accounting methods that allowed the unused vacation leave of employees of the facilities to be charged on an accrual basis. As a result of the accounting change, Missouri made a one-time adjustment to the base year costs for vacation leave that had accrued from 1976-1980 in addition to the leave accrued in FY 81. Missouri also included the amount of this adjustment in the base year rate computation for claims under its prospective reimbursement system for the period of the disallowance. HCFA argued that only the balance of leave accumulated during FY 81 could be included as a 1981 base year cost for purposes of determing prospective per diem rates in succeeding years. In reviewing this case, the board addressed two issues: (1) whether the state's inclusion of the costs from its accounting change in its base year computation is consistent with the applicable state plan and (2) whether the resulting rate is consistent with cost principles. The board found that the allowability of such costs was not addressed in the state plan, that the base year plan authorized reimbursement of employee services only when "actually compensated", and did not find that the accounting change represented extraordinary circumstances. In reviewing the cost principles, the board was concerned that inclusion of the five years of accrued leave in the base year rate would be claimed by the state indefinitely into the future. The board upheld the disallowance in full.

Issue: Disallowance of Claims for a Psychiatric Center Due to Loss of Accreditation.
New York State Department of Social Services, Decision No. 678, August 12, 1985

HCFA disallowed $4,416,550 in federal financial participation for Medicaid payments made to a psychiatric center for two categories of Medicaid claims:

(1) for inpatient hospital services for individuals age 65 and older in an institution for mental disease (IMD) for the period November 15, 1981 through January 28, 1982; and

(2) for inpatient psychiatric services to individuals under age 21 during the period August 26, 1981 through December 18, 1981.

For claims in category (1), HCFA requires that an IMD meet the Medicare definition of a psychiatric hospital, i.e., be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) or meet equivalent standards as determined by a "distinct part" survey performed by the state. For claims in category (2) above, HCFA requires the facility be JCAH-accredited.

In this rather complex case, the facility in question was surveyed on January 23, 1981 to determine if it continued to meet the "Special Conditions of Participation for Psychiatric Hospitals" under Medicare, was informed on May 11, 1981 that it did meet the requirements and was issued a Medicare agreement. On January 29, 1982, the facility was resurveyed to determine continued compliance with the special Medicare provisions and the state, on March 29, 1982, recommended to HCFA that the facility did, in fact, continue to meet the special Medicare conditions.

During this period, however, the facility lost JCAH accreditation. As a result of a survey conducted in September 1980, the facility lost is JCAH accreditation on August 26, 1981 and was notified by HCFA that its Medicare provider agreement was terminated effective November 15, 1981. Subsequently, JCAH awarded a two-year accreditation on December 19, 1981.

HCFA claimed in disallowing payments for patients in category (1) for the period December 19, 1981 (date JCAH accreditation was reinstated) through January 29, 1982 (date Medicare provider agreement renewed), that the facility did not meet the requirements of an IMD. However, the state claimed December 19, 1981 was an appropriate date for reinstatement of the Medicare agreement as the facility had continuously met the Medicare "special requirements" and was re-accredited by JCAH on this date. The board overturned this portion of the disallowance for the period December 19, 1981 through January 28, 1982 for claims for patients age 65 and older.

The remainder of the disallowance for the period August 26, 1981 (date of loss of JCAH accreditation) through December 18, 1981 (date immediately preceding reinstatement of JCAH accreditation) for individuals under age 21 was upheld by the board.

Issue: **Disallowance for Failure to Operate an Effective Program of Utilization Control in Long Term Care Facilities**
Virginia Department of Health, Decision No. 682, August 15, 1985

HCFA disallowed $315,526.84 claimed by Virginia for the quarter ending March 31, 1984 for failure to include 141 patients

residing in several long term care facilities in the state's annual medical review. As required by section 1903(g)(1)(D), a state must conduct mandatory on-site annual reviews of medical care provided to every Medicaid patient in certain long term care facilities. Virginia argued that it did, in fact, have an effective utilization control and quality of care review program in that it: (1) visited facilities every two months to assure high quality and facility compliance; (2) substantially conformed to federal requirements; and (3) had not previously been required to demonstrate that every patient in a facility had been reviewed.

The board upheld the disallowance citing that the state admitted that it did not even meet either of the conditions listed in section 1903 (g)(4)(B) that allows for a satisfactory showing even when the general requirement is not met. As set forth in section 1903 (g)(4)(B), the state did not meet the minimum requirement of reviewing 98% of participating facilities and all facilities with 200 or more beds nor did it fail to do so for a technical reason and come into compliance within 30 days.

Issue: Disallowance for Failure to Make Adjustments in Federal Financial Participation (FFP) for Overpayments to Providers.
New Jersey Department of Human Services, Decision No. 683, August 21, 1985

The board upheld the disallowance of FFP based on the fact that the state overpaid 16 long term care facilities over the period March, 1976 through January 21, 1984. FFP may be disallowed even if the state has yet to recover the overpayments from the providers. The board however did decrease the amount of the disallowance from $1,572,796 to $559,594.50 based upon more detailed information provided to the board by New Jersey than was ascertained by HCFA through its own review of the state's records.

Issue: Disallowance for Failure to Operate an Effective Program of Utilization Control in Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs)
West Virginia Department of Human Services, Decision No. 686, August 21, 1985

HCFA disallowed $440,442.60 claimed for services provided by ICFs and SNFs for the quarters ending March 30, 1984, June 30, 1984 and September 30, 1984 based on the findings of a validation survey which found that all Medicaid patients residing in 6 long term care facilities were not included in the state's annual reviews as required by section 1903 (g)(7)(D). In addition, HCFA found that, in two ICFs, services were provided to a patient who was certified as needing SNF services, contrary to certification and recertification requirements. The board upheld the disallowance for all facilities for the quarters ending March and June 1984 as the

state failed to meet annual review requirements. However, the board revised the disallowance for the quarter ending September 30, 1984 for the two ICFs cited above as the certification and recertification requirement was the only basis for this particular disallowance and those requirements were eliminated under provisions of the Deficit Reduction Act of 1984 effective July 1, 1984.

OF NOTE

"Medicaid DRG Hospital Reimbursement Systems: A Technical Guide for State Implementation", National Governors' Association, Health Policy Studies, June 1985.

This technical guide provides a range of information states may use in developing a DRG-based hospital reimbursement system for their individual state Medicaid programs. The report is organized to allow different audiences access to information of particular relevance to them. Included are chapters on: (1) the basic elements of a DRG-based system; (2) the process of developing and implementing a DRG system; (3) the extensive data base development and analysis needed to create DRG rates; and (4) modifications a state may need to make in related program areas.

For further information, please contact:

Publications Office
National Governors' Association
444 North Capitol Street, Suite 250
Washington, D.C. 20001
(202) 624-7880

COMING EVENTS

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October 15, 1985
Park Terrace Airport Hilton
St. Louis, Missouri

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- o mandatory enrollment of Medicaid recipients in HMOs;
- o Health Insuring Organizations (HIOs); and,
- o the impact of growing Medicaid enrollment on HMO operations.

For further information, please contact:

Conference Office
Group Health Foundation
624 Ninth Street, N.W.
Washington, D.C. 20001
(202) 737-4311

"Private Long Term Care Insurance: The Emerging Market"
American Health Care Association
November 21-22, 1985
St. Francis Hotel
San Francisco, California

This seminar follows up on the themes developed at the December 1984 conference on "Financing Long Term Care: The Need for Insurance". Subject areas covered by the November seminar include: (1) an overview of developments within the past year; (2) a look at new policies; (3) attention to state regulatory and legislative activity; (4) a discussion of model approaches to consumer education; and (5) an exploration of the market for group plans and quasi-insurance approaches.

For further information, please contact:

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The MIAP Bulletin is published monthly by the Medicaid Information and Assistance Project (MIAP) of the American Public Welfare Association, 1125 Fifteenth St., N.W., Washington, DC, 20005, (202) 293-7550. Circulation is limited.

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MIAP BULLETIN

No. 6
October 1985

FEDERAL REGISTER HIGHLIGHTS

Medicare and Medicaid Programs: Fraud and Abuse; 42 CFR Parts 420, 455, and 489; 45 CFR Part 101
Final Rule with comment period; September 13, 1985

This final rule, effective October 15, 1985, implements sections 2348 and 2370 of the Deficit Reduction Act (DEFRA) relating to fraud and abuse and contains the following provisions:

(1) Payments to home health and hospice providers whose provider agreements have been terminated may no longer be made through the end of the calender year in which the agreement was terminated. Under DEFRA, payments may only be made for services furnished up to 30 days after the provider agreement has been terminated and for recipients who were under a plan of care prior to the termination of the provider agreements.

(2) The subpoena authority of the Department of Health and Human Services (DHHS) in civil monetary penalty hearings has been expanded to include Medicaid (Title XIX) issues.

(3) Conforming changes to DHHS regulations have been made to reflect the transfer of authority for controlling fraud and abuse from the Health Care Financing Administration to the Office of Inspector General.

(4) Several technical modifications to the regulations have been made which: (a) clarify procedures for reinstating providers for matters involving fraud and abuse; (b) provide definitions for the terms "furnished" and "suspension"; and (c) correct errors in the civil monetary penalty regulations.

Although this rule is published as a final rule effective October 15, 1985, comments are solicited until October 28, 1985.

The MIAP Bulletin is published with support by a cooperative agreement (Grant No. 18-C-98220/3-02) awarded to APWA by the Health Care Financing Administration (HCFA), the U.S. Department of Health and Human Services (HHS).

Medicaid Program: Medicaid Management Information System (MMIS) Requirements for Physician and Supplier Services.
Final Notice; October 7, 1985

This notice describes two of five system requirement changes initially proposed on April 19, 1983. (A final notice published February 1, 1985 addressed the other three requirements).

For states with MMIS, the Medicaid agency will be required to accept and use exclusively:

(a) a common claim form for physicians, durable medical equipment suppliers, laboratories, chiropractors and podiatrists. This form is the revised HCFA-1500 which has been available for use by Medicare since January 1, 1984.

(b) uniform procedure coding system: the HCFA Common Procedure Coding System.

The requirements must be implemented by October 1, 1986 but will not be effective until Office of Management and Budget (OMB) approval has been obtained.

Also contained in this notice are responses to comments received on these changes.

COURT CASES

Issue: Use of community property laws in determining eligibilty for Medicaid
Washington Supreme Court No. 51068-7, July 18, 1985. 104 Wn. 2d 159

The Washington Department of Social and Health Services (DSHS), in determining the financial eligibility for Medicaid of married couples where one spouse resides in a nursing home, uses the "name on the instrument" rule in determining ownership of spousal income. This "rule" is an agency practice rather than a state law and is contrary to the community property laws of the state of Washington. In applying the "name on the instrument" rule, DSHS argues that its policy of disregarding community property law is mandated by federal Medicaid regulations. The Court ruled, however, that nothing in the Medicaid statute or regulations established federal criteria for determining ownership of income nor do provisions in the Medicaid Act intend to preempt state law in this circumstance. Washington's DSHS must apply the state's community property law of granting each spouse an undivided half-interest in the community property in determining financial eligibility for married couples.

Issue: Change in eligibility criteria in a 209(b) state
U.S. District Court, Western District of Missouri, Central Division No. 84-4292 CV-C-5, July 31, 1985

In April 1984, the state of Missouri and the Department of Health and Human Services (DHHS) sought to tighten Missouri's Medicaid financial eligibility criteria by eliminating the lifetime homestead exemption for nursing home residents which had been in effect since January 1, 1972. The plaintiffs in this case argued that Missouri, a 209(b) state, is prohibited, under 42 U.S.C. 1396a(f), from setting financial eligibility standards more restrictive than they were on January 1, 1972. The Secretary of DHHS asserted that a DHHS regulation, 42 CFR 435.121, overrides the statute in this case. The regulation states that while a 209(b) state cannot use eligibility criteria which are more restricive than its January 1, 1972 standards, neither can it use standards more liberal than eligibility criteria for Supplemental Security Income (SSI). The Court found that the DHHS regulation is in conflict with the statute and is therefore invalid in this case. Missouri is enjoined from implementing the April 1984 change in Medicaid financial eligibility criteria.

Issue: Transfer-of-Assets rule
U.S. Court of Appeals, Ninth Circuit, No. 84-3679, August 8, 1985

This case addresses whether an Oregon regulation is consistent with the federal transfer-of-assets rule which establishes a period of ineligibility for Medicaid for applicants who sold their home for less than fair market value during or after the 24 month period immediately prior to applying for Medicaid. Specifically at issue is the method in which the state calculates the period of ineligibility. In Oregon, Medicaid recipients are required to contribute all of their income and resources above a minimal amount kept for personal needs to the cost of their care in medical institutions. In determining the period of ineligibility under the transfer-of-assets rule for a home, the plaintiffs in this case contend that the total amount paid to the medical institution, including the applicant's share, should be divided into the uncompensated value of a home. Oregon argues that the amount paid to the medical institution by the state, excluding the applicant's share, is properly divided into the uncompensated value of a home to establish the period of ineligibility. The Court of Appeals reversed a lower court's decision and upheld the validity of the Oregon regulation.

Issue: Promulgation of regulations for the survey of the quality of care in nursing homes
U.S. District Court, District of Colorado, Civil Action No. 75-M-539, August 9, 1985

On April 29, 1985 the Courts ordered the Secretary of the Department of Health and Human Services (DHHS) to file a plan of action to promulgate regulations to implement a federal system of surveying quality of care in nursing homes. The Secretary submitted a plan of action on June 10, 1985 and on June 19, 1985 the plaintiffs filed a response to the plan and a motion for review proceedings. Subsequently, this Court ordered the Secretary of DHHS to develop and publish a notice of proposed rule making on this issue by October 31, 1985.

Issue: Six month spenddown period for determining financial eligibility for the medically needy - comparability of methods
U.S. Court of Appeals, First Circuit No. 85-1149, August 12, 1985 (Massachusetts) and U.S. Court of Appeals, Second Circuit No. 85-7327, August 12, 1985 (New York)

In two separate but similar rulings, the Courts found that both Massachusetts and New York may apply a six-month spenddown period for the purposes of determining financial eligibility for medically needy applicants. The plaintiffs in both cases asserted that the state agencies must employ the "same methodology" (Section 1902(a)(10)(C)(i)(III)) and "reasonable standards comparable for all groups" (Section 1902(a)(17)) when determining financial eligibility for both the categorically needy and for the medically needy when a state chooses to cover the medically needy as an optional category of recipient. Both states employ a one month budget period as required by federal regulation for the purposes of determining financial eligibility for Medicaid. However, since the "spenddown" provision for the medically needy does not have a counterpart in the categorically needy program and is an extra step in the eligibility process for the medically needy, the states are not bound to apply the one month budget period for spenddown purposes. Section 1902(a)(17) which addresses medically needy spenddown issues allows the states to adopt spenddown periods of up to 6 months for the medically needy and this provision was applied appropriately by Massachusetts and New York in these cases.

Issue: Transfer of property to applicant's children
Supreme Court, State of North Dakota. Civil No. 10,903, August 15, 1985

An applicant for medical assistance was denied eligibility by the North Dakota Department of Human Services (NDDHS) due to a disqualifying transfer of property to her daughters.

The applicant argued that the transferred property represented repayment to her daughters for services and contributions they had provided the applicant over the years. However, in North Dakota, there is a well-established presumption, upheld by the Courts, that "services rendered by a child to parents are gratuitous unless there is an express contract or the character of the services are peculiar and the circumstances are exceptional so as to imply a contract." The Court upheld the NDDHS decision to deny eligibility as no contractual agreement between parent and children was evident or implied.

Issue: **Federal payment for abortion services**
U.S. Court of Appeals, Eleventh Circuit, No. 84-8472, August 16, 1985.

After passage of the Hyde Amendment (1976) restricting the federal share of Medicaid payments for certain abortions and prior to the Supreme Court ruling on the constitutionality of the Hyde Amendment (Harris v. McRae, 1980), the U.S. District Court for the Northern District of Georgia issued a court order requiring the state to fund medically necessary abortions even absent federal financial participation. In this case, the state is seeking reimbursement from the Department of Health and Human Services (DHHS) for the federal share of payments for these abortions the state was compelled to finance. The state, citing 45 CFR 205.10(b)(3), argues that "payment of assistance within the scope of federally-aided public assistance programs [be] made in accordance with a court order." The Court, however, ruled that a regulation cannot take precedence over a statutory provision such as the Hyde Amendment and did not compel DHHS to reimburse Georgia for the federal share of payment for these abortions.

Issue: **Financial eligibility - availability of proceeds of probate court surcharge order**
Minnesota Court of Appeals, No. C3-85-528, August 20, 1985

The Court determined that proceeds of a probate court surcharge order in excess of $75,000 was a liquid asset available upon demand to an applicant for medical assistance. The Ramsey County Community Department of Human Services appropriately denied Medicaid eligibility to the applicant.

Issue: **Recipient's right to a hearing prior to discharge from a nursing home**
U.S. Court of Appeals, Fifth Circuit. No. 84-2352, September 3, 1985

The appellant in this case was discharged from a nursing home with three days notice and without a hearing and is

attempting to hold the state liable by asserting that the state lacks regulations sufficient to protect Medicaid recipients from having their federal statutory and regulatory rights infringed. The Court found, however, that private providers of services, such as the nursing home, derive their obligations from state law and through their contractual agreements with states and not from Title XIX.

Issue: **Coverage of Habilitative vs. Educational Services in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**
U.S. District Court, District of Massachusetts, Civil Action No. 83-2523-G, August 27, 1985

The court overturned a Grant Appeals Board disallowance of $6,414,964 for which the Board claimed the state of Massachusetts used to provide "educational" services rather than "habilitative" services under Medicaid. In Massachusetts, the Department of Mental Health (DMH) operates Medicaid-certified ICFs/MR and is responsible for their compliance with Title XIX statutes and regulations. The Bureau of Institutional Schools (BIS), a sub-division of the Massachusetts Department of Education, in compliance with state law (Chapter 766 of the Acts of 1972 M.G.L.c.71B), is responsible for administering educational programs at ICFs/MR. In an effort to promote efficiency while complying with both federal and state laws, Massachusetts consolidated the administration of services provided to residents of ICFs/MR by both DMH and BIS.

At issue in this case is whether services administered by BIS, including, in some cases, services in an ICF/MR resident's "individual education plan", are covered and reimbursable by the Medicaid program. These services were designed to assist the ICF/MR residents obtain or retain the capability for self-care or independence. The court found that although some of the services in question may also be covered under the "Education for All Handicapped Children Act of 1975" (20 USC § 1401) and the state's Chapter 766, these services involved "therapies designed to train the mentally retarded to function at some minimal level in society [and] cannot be defined as 'traditional' or 'academic' education" and are therefore allowable under the Medicaid program.

GRANT APPEALS BOARD DECISIONS

Issue: **Reduction of Federal Financial Participation (FFP) for failure to conduct annual medical care review for recipients in two Intermediate Care Facilities (ICFs)**
Vermont Agency of Human Services, Decision No. 687, August 22, 1985

The state received disallowances for failure to conduct an annual review for one patient residing in ICF facility A and

two patients residing in ICF facility B. In the case of facility A, the patient was admitted to the facility after the team had already begun its review and was not on the facility's rolls at the time the review team checked the facility census records on the first day of the review. Although HCFA asserted that Section 456.652(b)(2) required the state to include in its review all patients residing in an ICF at any time during the review period, the Board overturned this disallowance. The Board held that the first day of review was the relevant date indicating that a different interpretation may require the team to extend its review indefinitely since "a final check might always reveal a new patient". (cross-reference GAB Decision No. 650, South Dakota Department of Social Services, May 28, 1985 - MIAP BULLETIN, July 1985)

In the case of facility B, the state agreed that it did not conduct an annual review for two patients but disagreed with the decision to penalize it in two subsequent quarters, citing that section 1903(g)(1) imposed an annual requirement and 42 CFR section 456.652(b)(3) wrongly imposed a quarterly review requirement. The Board upheld the disallowance, stating that 1903(g) establishes a system that "continues to penalize a state for successive quarters until the state performs a review in a manner that complies with the applicable statutes and regulations."

Issue: Disallowance for expenses claimed at 75% federal financial participation (FFP) for skilled professional medical personnel (SPMP)
New Jersey Department of Human Services, Decision No. 688, August 26, 1985

The state asserted that supervisory medical review analysts (SMRAs) and medical review analysts (MRAs) in its Bureau of Administrative Control qualified for enhanced SPMP FFP at 62.5%. In reviewing these positions, the Board took into account the official position description, organizational placement, job announcement, and a listing in the handbook of occupational titles. The Board concluded that since the duties stated in the SMRA and MRA job descriptions mostly related to "how to recover monies or other types of non-medical activities," they did not qualify for SPMP FFP and upheld the disallowance.

Issue: Validity of provider agreements and application of "intermediate sanction" for five Intermediate Care Facilities (ICFs)
New York State Department of Social Services, Decision No. 691, September 11, 1985

The Health Care Financing Administration (HCFA) disallowed $58,134,341 in federal financial participation (FFP) for five

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) based on its determination that provider agreements for all five facilities were invalid. Under regulations in 42 CFR Part 442, Subpart G, facilities were given until July 18, 1982 to achieve full compliance with regulatory standards. The state granted additional short-term extensions for four of the facilities and established an "automatic cancellation date" of August 31, 1982. The central issue in this case concerns the state's application of the "intermediate sanction" provision of the Omnibus Reconciliation Act of 1980. On November 23, 1982 New York invoked the intermediate sanction for all facilities under the authority of section 1902(i) which allows continued certification of a facility for 11 months as long as the state denies payment for any new admissisons to the facility during the period of the sanction. HCFA maintained that this sanction was not applicable in that none of the facilities were in "substantial compliance" as required under section 1905(c) and that the intermediate sanction was not "meaningful." The Board ruled in favor of the intermediate sanction and overturned the disallowances for all facilities beyond the November 23, 1982 date. The Board upheld disallowances for 4 of the 5 facilities for the periods prior to November 23, 1982 when the state had neither granted a provider agreement extension nor had yet invoked the intermediate sanction.

Issue: Disallowance for overpayments not yet collected
Washington Department of Social and Health Services (DSHS), Decision No. 693, September 25, 1985

For the period January 1, 1978 through December 31, 1982, DSHS received disallowances of $4,355,512 based on a review of the state's policy to delay crediting the federal share of identified overpayments until the overpayments were collected from the providers. The Board, in reviewing this disallowance, addressed 3 issues:

a) The DSHS asserted that for the period of January 1, 1978 through June 30, 1981, a Judgment by the courts invalidated the facts on which the overpayments for this period were calculated. Both the state and HCFA agreed that the Judgment had the effect of retroactively modifying the state plan reimbursement methodology and the findings on which disallowance was based were no longer valid. The Board overturned the disallowance for this period.

b) The Board affirmed its position that HCFA has the authority to demand from states the federal share of identified Medicaid overpayments to providers prior to actual recovery

of those monies by the states (also see GAB Decision No. 645 in MIAP Bulletin, Issue No. 3, July 1985). The Board upheld the disallowance for the period July 1, 1981 through December 31, 1982 (the overpayment period not covered by the Court Judgment above).

c) The Board remanded for further development the disallowance for two facilities which had not submitted cost reports at all based on the state's intention to reconstruct the reports and on HCFA's willingness to examine the reconstructed cost reports.

OF NOTE

"Report to Congress: Studies Evaluating Medicaid Home and Community-Based Care Waivers", Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, December 1984 (released September 1985)

This report describes the key features, implementation status and program impacts of the Medicaid Home and Community-Based Care waiver program as of December 31, 1984. Information available at the early stages of program implementation is presented and is based on studies which comprise the first year of the Department's three-year evaluation of the waiver program. These studies focus on: a) an account of the ways in which states have chosen to implement Section 2176 waiver programs; and b) a preliminary analysis of the cost consequences of the waivers based on the earliest expenditure reports. The second and third years of the study will yield quantitative evidence of program impacts.

For further information, please contact:

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Health Care Financing Administration
2-B-16 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207
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(Please Note: Limited copies available)

COMING EVENTS

"Private Long Term Care Insurance: The Emerging Market"
American Health Care Association
November 21-22, 1985
St. Francis Hotel
San Francisco, California

This seminar follows up on the themes developed at the December 1984 conference on "Financing Long Term Care: The Need for Insurance". Subject areas covered by the November seminar include: (1) an overview of developments within the past year; (2) a look at new policies; (3) attention to state regulatory and legislative activity; (4) a discussion of model approaches to consumer education; and (5) an exploration of the market for group plans and quasi-insurance approaches.

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State Medicaid Directors' Association Conference
December 3 - 5, 1985
Dunes Hotel
Las Vegas, Nevada

For further information, please contact:

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MIAP BULLETIN

No. 7
November 1985

FEDERAL REGISTER HIGHLIGHTS

Medicaid Program: Federal Financial Participation (FFP) for Services of Long-Term Care Facilities; 42 CFR Part 442
Proposed rule with comment period; October 18, 1985

This proposed rule will clarify the conditions under which FFP is available for Medicaid payments to long-term care facilities whose provider agreement has been terminated or has not been renewed.

Currently, Program Regulation Guide MSA-PRG-11 is the basis by which FFP can be continued for long-term facilities whose provider agreements have been terminated or not renewed. FFP is allowed for a period of up to 12 months when state law or court order permits the continued validity of a provider agreement during the appeals process or the provider agreement is upheld during appeals and state law allows retroactive reimbursement.

This proposed role will rescind MSA-PRG-11, thus precluding continued FFP during appeals after termination of a provider agreement, regardless of court order or state law. FFP will still be available in a retroactive agreement issued by the state as a result of an appeal decision favorable to the facility unless HCFA determines that the facility does not meet the requirements of participation.

This change will not affect FFP under §441.11 and §442.16 which: (1) allows continued FFP for up to 30 days after termination of a provider agreement for the transfer of patients; and (2) permits a single two month extension of the agreement if the extension will not jeopardize the patient's health and safety and is needed to prevent irreparable harm to the facility or hardship to the recipients.

Consideration will be given to comments mailed by December 17, 1985.

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Unified Agenda of Regulations: Department of Health and Human Services; Health Care Financing Administration (HCFA)
October 29, 1985

Under Executive Order 12291 and the Regulatory Flexibility Act of 1980, the Department is required, on a semi-annual basis, to publish an agenda of significant regulations being developed. The Attachment to this issue of the Bulletin contains regulations affecting the Medicaid program which HCFA proposes to develop and publish during the next six months.

Medicare and Medicaid Programs: Long-Term Care Survey; 42 CFR Parts 405 and 442.
Proposed rule with comment period; October 31, 1985

Under court order, HCFA published this proposed rule regarding a new survey system that would enable better assessment of the quality of care being provided to Medicaid patients in nursing homes. This rule amends §442.30(a) of the Medicaid rules to emphasize that State survey agencies must follow the survey methods and procedures prescribed by HCFA current at the time of their survey. Medicare regulations (§405.1906) would also be amended to reflect this change, and the new survey process would apply to both Medicare and Medicaid participating facilities.

This proposed rule also describes a new survey procedure which HCFA plans to implement in 1986. The new survey procedure, the Patient Care and Services (PaCS) survey, has two key features: (1) it is outcome-oriented and focuses more directly on observing actual patient care; and (2) it is intended to achieve greater consistency by requiring surveyors to follow specific procedures and review a specific checklist. This is a departure from the current survey process which focuses on structural requirements.

Since the PaCS survey does not examine each participation requirement of the regulations, each facility, at the time of its initial survey, would be measured against all items of the current survey form in order to be certified. At the time of resurvey, the facility would be required to sign a statement affirming that it continues to meet all participation requirements not directly assessed by the PaCS survey.

Copies of the proposed survey methodology are available from HCFA's Office of Survey and Certification. Comments on this proposed rule must be received by HCFA by 5:00 p.m. on December 30, 1985.

Medicaid Program: Fire Safety Standards for ICFs/MR; 42 CFR Part 442
Proposed Rule with comment period; November 5, 1985

This proposed rule amends existing standards on fire safety (§442.507-442.509) for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) by requiring compliance with the 1985 edition of the Life Safety Code (LSC) of the National Fire Protection Association, rather than the 1981 edition currently required.

In addition, the proposed rule will make it easier for small (16 beds or less) ICFs/MR to receive Medicaid certification. Under the proposed rule, use of the 1985 edition of the LSC would incorporate a new chapter (21) applicable to "Residential Board and Care Occupancies". The new provisions are designed to assure client safety and provide reasonable alternatives for facility compliance by taking into consideration the characteristics of the staff and the clients, as well as the fire protection features of the facility structure. The current regulations have been characterized as too rigid in that they require patients in small facilities to be "ambulatory" -- able to walk without assistance.

Comments on this proposed rule must be received by HCFA by December 5, 1985.

Medicaid Program: Third Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation; 42 CFR Parts 432, 433, 435 and 436
Final Regulations; November 12, 1985

These final regulations, covering three Medicaid program areas--third party liability, federal financial participation (FFP) for skilled professional medical personnel (SPMP) and the state share of financial participation--removes unnecessary requirements in the regulations and conforms the regulations to the statutory provisions of the Deficit Reduction Act of 1984. The specific provisions of these regulations are detailed at length in the Federal Register and are only briefly summarized below:

(1) Third Party Liability (TPL)

(A) Broader definitions - The regulations broaden the definitions of "third party" and "private insurer" so as

not to limit collections to expenditures for services relating to the diagnosis or treatment of an injury, disease or disability.

(B) Payment of claims involving third party liability - State Medicaid agencies will be required to use the "cost avoidance" method of payment in circumstances where the probable existence of third party liability is established at the time the claim is filed.

(C) Assignment of medical support rights and cooperative agreements for third party collections - Requires state Medicaid agencies to solicit cooperation in establishing paternity and seeking support and other payments as a condition for Medicaid eligibility. State Medicaid agencies will seek cooperative agreements for the enforcement of rights to third party collections from the state child support enforcement (title IV-D) agency or other appropriate state agency and from appropriate courts and law enforcement officials.

(2) Rules of Federal Financial Participation (FFP) for Compensation and Training of Skilled Professional Medical Personnel (SPMP)

Summarized briefly are the major provisions related to FFP for SPMP:

(A) Costs must be for activities directly related to the administration of the Medicaid program.

(B) SPMP must have professional training in a medical field.

(C) Professional medical expertise must be necessary to fulfill the responsibilities of the SPMP's position.

(D) An employer-employee relationship must exist between the state agency and the SPMP and directly supporting staff.

(E) The directly supporting staff must provide clerical services that are directly necessary for carrying out the professional medical responsibilities and functions of the SPMP.

(F) SPMP and directly supporting staff of other public agencies must meet all of the applicable criteria delineated above and must be verified in a written agreement with the Medicaid agency.

(G) FFP must be prorated for split functions of SPMP and directly supporting staff.

(3) Sources of State's Share of Financial Participation

Section 432.60 outlines the conditions under which public and private funds may be considered as the state's share of Medicaid expenditures. Under these final regulations, the requirements under §432.60 are revised to permit public and private donations to be used as a state's share of financial participation in the entire Medicaid program, rather than just training expenditures.

COURT CASES

Issue: Disregarding COLAs of ineligible family members in assessing claimant's Medicaid eligibility
U.S. District Court, Northern District of California, No. C-83--2340 WHO, August 20, 1985.

The California court ruled in this case that, when calculating total income for assessment of Medicaid eligibility, Title II cost-of-living adjustments (COLAs) must be excluded, whether received by claimants or by any financially responsible family members whose income is counted in determining eligibility.

Congress adopted the Pickle Amendment to the Social Security Act (42 U.S.C. §1396a) to ensure that no Supplemental Security Income (SSI) recipient would lose Medicaid eligibility as a result of COLA increases in SSI benefits. While the statutory language of the Pickle Amendment is ambiguous regarding treatment of an ineligible spouse's COLA income when calculating a claimant's Medicaid eligibility, the court ruled in favor of excluding the COLAs of both claimants and ineligible family members, based on Congressional intent and the "plain purpose" of the law.

Issue: Federal payment for abortion services
U.S. Court of Appeals, Seventh Circuit, No. 84-2535, August 30, 1985.

In this case, Illinois sought federal financial participation (FFP) for abortion services that did not comply with the Hyde Amendment (1976) but which the state was under court order to provide.

In 1977, Illinois passed legislation (P.A.80-1091) prohibiting state funding for any abortion unless necessary to save the

life of the mother. A series of federal court injunctions prohibited the law's enforcement. During the appeals process, the Illinois Department of Public Aid (DPA) was required to pay for therapeutic abortions disallowed for FFP by the Hyde Amendment (1976).

The state sought FFP reimbursement for all abortions performed during this period, offering three arguments:(1) the state was under federal court order to provide the abortion services, (2) the principle of "cooperative federalism" placed HHS "in active concert or participation" with the state and thus bound them to the requirements of the court order, and (3) an HHS regulation provided for reimbursement.

All three arguments were rejected by the Seventh Circuit Court, which ruled that "no legal basis exists to require federal reimbursement for DPA expenditures".

This ruling is consistent with another recent court decision (see Bulletin, October 1985), in which Georgia, also under court order to fund abortions not in compliance with the Hyde Amendment, was denied FFP reimbursement.

Issue: Medicaid coverage of Intermediate Care Facilities (ICFs) offering treatment for alcoholism
U.S. Court of Appeals, Eighth Circuit, No. 84-5195, September 6, 1985.

In this case, Granville House, Inc. v. HHS, the court was asked to address whether alcoholism may be classified as a mental disease and whether treatment of alcoholism in an ICF qualifies for federal financial participation (FFP) under Medicaid.

A district court had earlier ruled on Granville, in consolidation with a related case, and prohibited the Department of Health and Human Services (HHS) from denying Medicaid funds to any ICF in Minnesota on the grounds that it is an institution for mental disease (IMD) until HHS developed regulations to determine whether, and in what circumstances, an ICF is an IMD. (Under 42 U.S.C. §1396d(a), no FFP is available for medical services to persons aged 19-65 in an IMD.)

In this appeal, the Eighth Circuit Court held that the lower court erred in ordering HHS to develop guidelines through the notice and comment process and in prohibiting the denial of Medicaid funds. The matter was remanded back to the district court. On remand, the Health Care Financing Administration (HCFA) is to develop guidelines that will enable HCFA and the states to more clearly evaluate "what types of alcoholism treatment are, and are not, conclusive of IMD status."

Issue: Medicaid eligibility in §209(b) states in light of the SSI Homestead Exemption.
Missouri Court of Appeals, Eastern District, First Division No. 49272, September 10, 1985

This case reviewed Missouri's denial of benefits to a Medicaid applicant who owned property valued in excess of Missouri's eligibility standard. The applicant contended that, based on the Supplemental Security Income (SSI) "homestead provision" [42 U.S.C. §1382b(a)(1)], the value of her home and 30 acres of land should not be included in determining her Medicaid eligibility.

The court ruled that Missouri's participation in the "Section 209(b) option" [42 U.S.C.§1396a(f)] allows that state to restrict Medicaid eligibility to individuals who would have qualified under the state Medicaid plan in effect on January 1, 1972. In Missouri, "property of any kind" is included in eligibility calculations for Medicaid. Section 209(b) was, therefore, found to supercede the SSI homestead provision, consistent with Congressional intent that this option allow states to use more restrictive standards for Medicaid than are mandated by SSI eligibility criteria.

This case reverses a previous Missouri appellate court decision in Rock v. Toan (657 S.W. 2d 707) (Mo. App. 1983), in which the value of an applicant's home was ordered to be excluded in determining her Medicaid eligibility.

Issue: Recovery of benefits from decedent's estate
New York Supreme Court, Appellate Division, Second Judicial Department, September 16, 1985

The court ruled in this appeal that recovery of correctly paid medical assistance benefits from a decedent's estate is permissible as long as there are no survivors who had been financial dependents.

The petitioner in this case had asserted that recovery of benefits from his deceased mother's estate was barred under New York Social Services Law §369(1)(b) [directly derived from Federal enabling legislation 42 U.S.C. §1396p(b)(2)], which prohibits recovery of medical assistance benefits from an estate where there is a surviving spouse, child under age 21, or child who is blind or permanently and totally disabled. Although the decedent's daughter (who was not the petitioner) fit this latter category, she had not been dependent upon the decedent since 1979 and was not a beneficiary of her mother's estate. Therefore, the court affirmed the decision that, although the literal terms of the law supported the petitioner's claim, a literal

interpretation would be contrary to the intent of the law, which was to protect those individuals who were financially dependent on the decedent. The court further emphasized that if recovery were disallowed in this case, the beneficiary of the financial gain would be the petitioner, who was the sole heir to the decedent's estate, a result clearly not intended by the statute.

GRANT APPEALS BOARD DECISIONS

For the month of October, 1985 no Medicaid-related decisions were handed down by the Grant Appeals Board.

OF NOTE

"Prepaid and Managed Care Under Medicaid: Characteristics of Current Initiatives"
National Governors' Association, Health Policy Studies, October, 1985

This report describes state initiatives in the areas of prepaid health care and primary care case management for acute care services for the Medicaid population. It is intended to serve as a resource and reference for states that are developing, or considering whether to develop such initiatives, and to make available to state Medicaid agencies and other interested parties relatively detailed information on the managed health care initiatives being undertaken in each state.

For further information, please contact:

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National Governors' Association
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COMING EVENTS

State Medicaid Directors' Association Conference
December 3 - 5, 1985
Dunes Hotel
Las Vegas, Nevada

For further information, please contact:

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"Systems Integration: Compounding the Cubes--A National Working Conference"
American Health Planning Association and the Veterans Administration Department of Medicine and Surgery
December 15 - 18, 1985
Hyatt Regency Baltimore and
Sheraton Inner Harbor Hotel
Baltimore, Maryland

This conference, designed to bring together those concerned with the integration of acute and long-term care financing and service delivery, will focus on the interdependency of this issue's many component parts and the problems and barriers handering effective collaboration.

For further information, please contact:

American Health Planning Association
1110 Vermont Avenue, N.W., Suite 950
Washington, D.C. 20005
(202) 861-1200

"Capitated Rates and Medicaid"
National Governors' Association
January 22-24, 1986
Long Beach, California

The National Governors' Association will host a conference on issues related to the capitation of the Medicaid population for primary care services. Issues, such as the capitated rate calculation by the state and subsequently by the health plans, the purchase of "stop-loss" insurance, and risk-sharing under partially-capitated arrangements, will be covered.

The Medicaid Information and Assistance Project (MIAP) is currently investigating the feasibility of arranging a "900" teleconference hookup for this conference to allow state staff unable to attend the conference in person to attend the sessions via a one-way telephone system.

Further details concerning this possibility will be included in future issues of the Bulletin and in conference materials.

For further information on the conference details, please contact:

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ATTACHMENT

. MEDICAID OVERPAYMENT REPORTING REQUIREMENTS

Significance: Agency Priority

Legal Authority: 31 USC 951 to 953; 42 USC 1302

CFR Citation: 42 CFR 447.401 to 447.431

Abstract: This regulation requires States to establish procedures to establish overpayments made to providers of services and report and refund them to HCFA on a timely basis. It is intended to reduce State and Federal Medicaid costs and improve program efficiency.

Timetable:

Action	Date	FR Cite
NPRM	04/05/83	48 FR 14664
Final Action	10/00/85	

Small Entity: No

Agency Contact: Dan Metzman, Division Director, Department of Health and Human Services, Health Care Financing Administration, Div. of Provider Overpayments, Room 1-B-2, Meadows East Bldg, 6300 Security Blvd, Baltimore, MD 21207, 301 594-8194

RIN: 0938-AA04

5. CONDITIONS OF PARTICIPATION FOR HOSPITALS

Significance: Regulatory Program

Legal Authority: 42 USC 1395t; 42 USC 1396d; 42 USC 1395hh; 42 USC 1395x; PL 98-369, Sec 2335; PL 98-369, Sec 2340

CFR Citation: 42 CFR 1011 to 1042; 42 CFR 416.41; 42 CFR 440.1; 42 CFR 440.10; 42 CFR 440.40; 42 CFR 440.140-150; 42 CFR 440.250; 42 CFR 441.11; 42 CFR 441.13; 42 CFR 441.40; 42 CFR 456.51; 42 CFR 456.501; 42 CFR 489.21; 42 CFR 482

Abstract: This regulation simplifies requirements which hospitals must meet to be certified to participate in Medicare and Medicaid. It is intended to reduce Federal requirements, simplify and clarify regulations, and provide maximum flexibility in hospital administration while strengthening patient health and safety. This regulation is a review item of the Presidential Task Force on Regulatory Relief. It also conforms Medicare regulations to statutory changes made by PL 98-369 regarding certification of psychiatric and tuberculosis hospitals.

Timetable:

Action	Date	FR Cite
NPRM	01/04/83	48 FR 299
Final Action	10/00/85	

Small Entity: Yes

Agency Contact: Sheila Ryan, Division Director, Department of Health and Human Services, Health Care Financing Administration, Division of Standards and Certification, 300 EHR, 6325 Security Blvd., Baltimore, MD 21207, 301 594-3775

RIN: 0938-AA23

669. SURVEY AND CERTIFICATION PROCEDURES

Significance: Agency Priority

Legal Authority: 42 USC 1395t; 42 USC 1395x; 42 USC 1395bb; 42 USC 1395cc; 42 USC 1395hh; 42 USC 1396a; 42 USC 1396(i)

CFR Citation: 42 CFR 405; 42 CFR 431; 42 CFR 481; 42 CFR 442; 42 CFR 489; 42 CFR 490; 42 CFR 455; 42 CFR 485; 42 CFR 488; 42 CFR 491

Abstract: This regulation would streamline, simplify and integrate survey and certification procedures for providers and suppliers under Medicare and Medicaid. It is intended to accomplish effective monitoring with greater flexibility to States without loss of quality of health services.

Timetable:

Action	Date	FR Cite
NPRM	05/27/82	47 FR 23404
Final Action	01/00/86	

Small Entity: Undetermined

Agency Contact: Walter Merten, Division Director, Department of Health and Human Services, Health Care Financing Administration, Div. of Survey Procedures and Training, 2-K-1 DWE, 1849 Gwynn Oak Ave., Baltimore, MD 21207, 301 594-3812

RIN: 0938-AA38

671. MEDICAID ELIGIBILITY

Legal Authority: PL 97-248, Sec 137(b); PL 98-369, Sec 2373; PL 97-35, Sec 2171; PL 97-35, Sec 2172

CFR Citation: 42 CFR 435; 42 CFR 436

Abstract: This regulation would implement changes with respect to Medicaid eligibility groups and coverage criteria made by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Deficit Reduction Act of 1984 (PL 98-369). Most of these changes affect the provisions of September 30, 1981 regulations concerning Medicaid eligibility for the medically needy, published as a result of the Omnibus Budget Reconciliation Act of 1981. The regulations would also respond to public comments received on the September 30 regulations. Because of changes required by TEFRA and in order to respond to comments, an NPRM will be published rather than a final regulation.

Timetable:

Action	Date	FR Cite
NPRM	03/00/86	

Small Entity: No

Agency Contact: Marinos Svolos, Division Director, Department of Health and Human Services, Health Care Financing Administration, Div of Medicaid Eligibility, Room 416, East High Rise Bldg, 6325 Security Blvd, Baltimore, MD 21207, 301 594-9050

RIN: 0938-AA58

672. INTERMEDIATE SANCTION OF LONG-TERM CARE FACILITIES

Significance: Regulatory Program

Legal Authority: 42 USC 1302; 42 USC 1395, 42 USC 1395x; 42 USC 1395aa; 42 USC 1395cc; 42 USC 1395hh

CFR Citation: 42 CFR 405.1501; 42 CFR 405.1502; 42 CFR 442.1 to 442.2; 42 CFR 442.117 to 442.119; 42 CFR 489.1 to 489.3; 42 CFR 489.50; 42 CFR 489.53; 42 CFR 489.60; 42 CFR 489.62; 42 CFR 489.64; 42 CFR 489.66

Abstract: This regulation authorizes the Secretary and State Medicaid agencies to impose an alternative to terminating long-term care facilities found to be out of compliance with the Medicare conditions of participation or the Medicaid conditions of participation or standards in facilities where deficiencies do not pose an immediate jeopardy to patient health and safety.

HCFA and the State Medicaid agency may deny payment for new admissions to the facilities.

Timetable:

Action	Date	FR Cite
NPRM	02/21/85	50 FR 07191
Final Action	11/00/85	

Small Entity: No

Agency Contact: Matthew Brown, Branch Chief, Department of Health and Human Services, Health Care Financing Administration, Long Term Care Services Br., Rm. 2-D-2 ME, 6300 Security Blvd., Baltimore, MD 21207, 301 594-7617

RIN: 0938-AA60

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673. ● MMIS: (1) DEFINITION OF "IMPROVEMENT" AND "MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEM" AND (2) NOTICE OF THE MEDICAID ELIGIBILITY DETERMINATION AND INFORMATION ETC

Significance: Regulatory Program

Legal Authority: 42 USC 1302; 42 USC 1396b

CFR Citation: 42 CFR 433.111

Abstract: This rule would change the definitions of "improvement" and of "mechanized claims processing and information retrieval systems" to clarify under what circumstances we will pay Federal financial participation at a percentage higher than 50 percent for a Medicaid Management Information System. It would also serve as a notice, announcing a new subsystem called the Medicaid Eligibility and Information Retrieval System for State Medicaid agencies to implement at their option.

Timetable:

Action	Date	FR Cite
NPRM	12/00/85	

Small Entity: No

Additional Information: TITLE CONT: Retrieval System.

Agency Contact: William Grant, Division Director, Department of Health and Human Services, Health Care Financing Administration, Division of Methods & Systems Requirements, 2-A-1 Meadows East, 6325 Security Blvd., Baltimore, MD 21207, 301 594-7847

RIN: 0938-AA63

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674. THIRD PARTY LIABILITY (TPL), PREMIUM FFP RATES, MANDATORY ASSIGNMENT OF RIGHTS TO PAYMENTS; SOURCES OF STATE FUND

Significance: Regulatory Program

Legal Authority: 42 USC 1396a(a)(25); 42 USC 1396b(d)(2); PL 98-369, Sec 2307; 42 USC 1396a(a)(2); 42 USC 1396a(a)(45); 42 USC 1396k; 42 USC 1396b

CFR Citation: 42 CFR 432.2; 42 CFR 432.50; 42 CFR 432.60; 42 CFR 433.15; 42 CFR 433.45; 42 CFR 433.136; 42 CFR 433.139; 42 CFR 433.149; 42 CFR 433.151 to 433.152; 42 CFR 433.145; 42 CFR 433.137; 42 CFR 435.604; 42 CFR 432.45; 42 CFR 433.135; 42 CFR 436.604; ...

Abstract: This regulation provides States with flexibility in establishing their programs so as to maximize operational efficiency and promote cost-avoidance procedures. It is intended to promote program management efficiency and reduce program costs by increasing TPL recoveries. This regulation also conforms the Medicaid regulations to statutory changes that require Medicaid applicants and recipients to assign to the State their rights to medical support and other third party payments and to cooperate in establishing paternity and securing support as a condition of eligibility.

Timetable:

Action	Date	FR Cite
NPRM	06/04/84	49 FR 23078
Final Action	10/00/85	

Small Entity: No

Agency Contact: David McNally, Director, Department of Health and Human Services, Health Care Financing Administration, Div. of State Agency Financial Management, Room 350, Meadows East, 6325 Security Blvd., Baltimore, MD 21207, 301 597-1398

RIN: 0938-AA65

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675. MENTAL RETARDATION--DEFINITION OF "PERSONS WITH RELATED CONDITIONS"

Legal Authority: 42 USC 1302; 42 USC 1396d

CFR Citation: 42 CFR 435.1009

Abstract: This regulation would amend Medicaid regulations on intermediate care facility services for the mentally retarded persons with related conditions by revising the current definition of "persons with related conditions." This definition is presently tied to the definition of developmental disability in the Developmental Disabilities Assistance and Bill of Rights Act (DDABRA). This regulation establishes a Medicaid definition of conditions related to mental retardation that would meet the specific needs of the Medicaid program and would be independent of the definition of developmental disability in the DDABRA.

Timetable:

Action	Date	FR Cite
NPRM	02/23/83	48 FR 7593
Final Action	10/00/85	

Small Entity: Yes

Agency Contact: Robert Wren, Office Director, Department of Health and Human Services, Health Care Financing Administration, Office of Coverage Policy, Room 403, East High Rise Bldg. 6325 Security Blvd, Baltimore, MD 21207, 301 594-9690

RIN: 0938-AA78

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676. PAYMENTS TO INSTITUTIONS

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 435.722; 42 CFR 435.725; 42 CFR 435.733; 42 CFR 435.832; 42 CFR 436.832

Abstract: This regulation alleviates problems encountered by States in calculating patient income to be applied to the cost of care in institutions. It is intended to permit States greater flexibility in administering their programs (Regulatory Reform).

Timetable:

Action	Date	FR Cite
NPRM	03/19/85	50 FR 10992
NPRM Comment Period Begin	03/19/85	
NPRM Comment Period End	05/20/85	
Final Action	06/00/86	

Small Entity: No

Agency Contact: Marinos Svolos, Division Director, Department of Health and Human Services, Health Care Financing Administration, Division of Medicaid Eligibility, Room 416 East High Rise, 6325 Security Blvd., Baltimore, MD 21207, 301 594-9050

RIN: 0938-AB00

67[illegible] MISCELLANEOUS CONFORMING AMENDMENTS

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 405; 42 CFR 409; 42 CFR 431; 42 CFR 433; 42 CFR 435; 42 CFR 441

Abstract: These rules amend existing Medicare and Medicaid regulations to conform them to statutory and policy changes that have occurred since those regulations were last published. The pertinent statutory changes are primarily those contained in the Omnibus Reconciliation Act of 1980 (P.L. 96-499) and in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), the Social Security Amendments of 1983 (P.L. 98-21), and the Continuing Appropriations for Fiscal Year 1982 (P.L. 97-101).

Timetable:

Action	Date	FR Cite
NPRM	12/00/85	

Small Entity: No

Agency Contact: Luisa Iglesias, Technical Assistant, Department of Health and Human Services, Health Care Financing Administration, BERC Regulations Staff, Rm. 4230 North, 300 Independence Ave., SW, Washington, DC 20201, 202 245-0383

RIN: 0938-AB05

679. SPENDDOWN

Significance: Agency Priority

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 435.732; 42 CFR 435.831; 42 CFR 436.831

Abstract: These regulations permit States to revise the process by which medical expenses are considered in determining Medicaid eligibility. This process applies when an individual's income level during a budget period would ordinarily preclude eligibility except that incurred medical expenses reduce income to the eligibility level.

Timetable:

Action	Date	FR Cite
NPRM	09/02/83	48 FR 39959
NPRM Comment Period Begin	09/02/83	
NPRM Comment Period End	11/01/83	
Final Action	12/00/85	

Small Entity: Undetermined

Agency Contact: Marinos Svolos, Director, Div. of Medicaid Eligibility, Department of Health and Human Services, Health Care Financing Administration, Room 416 East High Rise Bldg., 6325 Security Boulevard, Baltimore, MD 21207, 301 594-9050

RIN: 0938-AB07

680. RELATIONS WITH OTHER AGENCIES - BUY-IN, AND MISCELLANEOUS MEDICAID DEFINITIONS

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 431.625; 42 CFR 435.1009; 42 CFR 440.2; 42 CFR 440.10; 42 CFR 440.20; 42 CFR 440.80; 42 CFR 440.160; 42 CFR 441.151; 42 CFR 447.40; 42 CFR 431.800; 42 CFR 440.30; 42 CFR 435.1007

Abstract: These regulations: (1) revise Medicaid policy on State payments of cost sharing amounts under Medicare Part B "buy-in" agreements; (2) revise and clarify certain Medicaid definitions; (3) remove the requirement that State plans include third party liability quality control reviews as a part of the State's Medicaid quality control system; and (4) clarify the limitation on Federal financial participation (FFP) with regard to the medically-needy income level for one person.

Timetable:

Action	Date	FR Cite
NPRM	03/11/83	49 FR 10378
NPRM Comment Period Begin	03/11/83	
NPRM Comment Period End	05/11/83	
Final Action	00/00/00	

Small Entity: No

Agency Contact: Thomas Hoyer, Director, Division of Provider Services, Department of Health and Human Services, Health Care Financing Administration, Room 409 EHR, 6325 Security Boulevard, Baltimore, MD 21207, 301 594-9446

RIN: 0938-AB21

684. ADJUSTMENT OF FEDERAL SHARE FOR UNCASHED OR FOR CANCELLED (VOIDED) MEDICAID CHECKS

Legal Authority: 42 USC 1302

CFR Citation: 45 CFR 201.5; 45 CFR 201.67; 42 CFR 430.0

Abstract: This rule requires a State agency to refund to the Federal government the Federal share of Medicaid checks that remain uncashed 180 days after issuance and would require that the federal share of cancelled (voided) Medicaid checks be refunded quarterly because there has not been an expenditure of funds in either case.

Timetable:

Action	Date	FR Cite
NPRM	05/31/85	50 FR 23147
NPRM Comment Period Begin	05/31/85	
NPRM Comment Period End	07/01/85	
Final Action	03/00/86	

Small Entity: No

Agency Contact: David McNally, Director, Div. of State Agency Financial Mgt, Department of Health and Human Services, Health Care Financing Administration, Room 350 Meadows East Building, 6325 Security Boulevard, Baltimore, MD 21207, 301 597-1398

RIN: 0938-AB35

685. REVISIONS TO MEDICAID PAYMENT FOR INPATIENT HOSPITAL AND LONG-TERM CARE FACILITY SERVICES

Significance: Agency Priority

Legal Authority: 42 USC 1302; 42 USC 1396a(a)(30); 42 USC 1396a(a)(13); 42 USC 1396i; PL 98-369, Sec 2369(a)

CFR Citation: 42 CFR 447.253; 42 CFR 447.272; 42 CFR 447.321; 42 CFR 447.257; 42 CFR 447.280

Abstract: This regulation would make several changes to the procedural requirements for States to obtain approval of their inpatient reimbursement rates. It is intended that these changes would promote increased economy in the administration of the Medicaid program while retaining State flexibility to the maximum extent possible.

Timetable:

Action	Date	FR Cite
NPRM	07/00/85	
Final Action	10/00/85	

Small Entity: No

Agency Contact: Tzvi Hefter, Program Analyst, Department of Health and Human Services, Health Care Financing Administration, Long Term Care Section, Room 1-A-1 ELR Bldg., 6325 Security Blvd., Baltimore, MD 21207, 301 597-1808

RIN: 0938-AB40

686. FFP FOR LTC FACILITIES AFTER TERMINATION OF PROVIDER AGREEMENT

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 442.16

Abstract: These rules would modify and clarify policy on Federal financial participation (FFP) in State Medicaid payments to a skilled nursing facility (SNF) or an intermediate care facility (ICF) after the facility's provider agreement has been terminated or has expired and not been renewed.

Timetable:

Action	Date	FR Cite
Final Action	10/00/85	

Small Entity: No

Affected Sectors: 919 General Government, Not Elsewhere Classified

Government Levels Affected: State

Agency Contact: Gilda Martin, Program Analyst, Department of Health and Human Services, Health Care Financing Administration, Financial Policy Branch, Rm. 350 Meadows East, 6325 Security Blvd., Baltimore, MD 21207, 301 597-1399

RIN: 0938-AB42

687. OFFICE OF MANAGEMENT AND BUDGET REQUEST FOR REVIEW OF REPORTING AND RECORDKEEPING REQUIREMENTS

Legal Authority: 42 USC 1302; 42 USC 1395x(p), 42 USC 1395x(s)(3)(11) and (12); 42 USC 1395aa; 42 USC 1395hh

CFR Citation: 42 CFR 405.1413(c); 42 CFR 405.1716(c); 42 CFR 405.1716(d); 42 CFR 405.1717(b); 42 CFR 405.1717(e); 42 CFR 405.1725(a); 42 CFR 405.1702(d), (f) - (k); 42 CFR 405.1731(a),(c); 42 CFR 434.36; 42 CFR 434.55; 42 CFR 405.1733(a),(b); 42 CFR 434.27(a)

Abstract: This proposed rule sets forth recommendations made by the Office of Management and Budget for changes in several regulations containing collection of information requirements, and HCFA responses to those recommendations. The requirements affect the providers and suppliers of outpatient physical therapy and speech pathology services; physical therapists in independent practice; portable X-ray services; and Medicaid contracts with health maintenance organizations and prepaid health plans.

Timetable:

Action	Date	FR Cite
Final Action	10/00/85	

Small Entity: No

Agency Contact: Stefan Miller, Laboratory and Ambulatory Branch Chief, Department of Health and Human Services, Health Care Financing Administration, 300 East High Rise Bldg., 6325 Security Blvd., Baltimore, Maryland 21207, 301 597-6394

RIN: 0938-AB46

689. HMOS AND CMPS; DEFICIT REDUCTION ACT PROVISIONS

Legal Authority: 42 USC 1903(m)

CFR Citation: 42 CFR 434.26; 42 CFR 434.27

Abstract: These regulations would implement certain provisions of section 2364 of the Deficit Reduction Act of 1984 as those provisions affect HMOs and CMPs in the Medicaid Program.

Timetable:

Action	Date	FR Cite
NPRM	12/00/85	

Small Entity: No

Agency Contact: Robert E. Wren, Office Director, Department of Health and Human Services, Health Care Financing Administration, Office of Coverage Policy, Room 401 EHR, 6325 Security Blvd., Baltimore, MD 21207, 301 594-9690

RIN: 0938-AB54

690. PHYSICIAN CERTIFICATION AND PLAN OF REQUIREMENTS AND INSPECTION OF CARE REVIEWS

Legal Authority: 42 USC 1302; PL 98-369, Sec 2363 and 2368

CFR Citation: 42 CFR 440; 42 CFR 441; 42 CFR 456

Abstract: These rules would implement Sections 2363 and 2368 of the Deficit Reduction Act of 1984. The rules would make the requirements for physician certification and development of a plan of care (formerly utilization control requirements) State plan requirements. States would no longer be required to make the quarterly showings of compliance for those requirements or for utilization review. A quarterly demonstration to the Secretary of a satisfactory utilization control program would be limited to inspections of care in participating mental hospitals, skilled nursing facilities and intermediate care facilities, including intermediate care facilities for the mentally retarded. The purpose is to focus the quarterly showing (and the risk of a utilization control penalty) on inspection of care, the procedure that is most likely to ensure quality of care, by providing incentives for improvement of inadequate facilities.

Timetable:

Action	Date	FR Cite
NPRM	11/00/85	

Small Entity: Yes

Agency Contact: Thomas E. Hoyer, Division Director, Department of Health and Human Services, Health Care Financing Administration, Div. of Provider Services & Coverage Pol., Rm. 405 EHR, 6325 Security Blvd., Baltimore, MD 21207, 301 594-9446

RIN: 0938-AB55

696. TREATMENT OF SOCIAL SECURITY COST OF LIVING INCREASES FOR INDIVIDUALS WHO LOSE SSI ELIGIBILITY

Significance: Agency Priority

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 435.135

Abstract: This revision to Medicaid rules provide that a State, in determining categorically needy financial eligibility for an individual who would still be eligible for benefits under SSI but for receipt of a section 215(i) cost of living increase after April 1977, must treat that individual as if he or she were still receiving SSI benefits. Section 215(i) cost of living increases are made to persons who receive monthly Social Security cash benefits. (This regulation is being developed pursuant to a court order.)

Timetable:

Action	Date	FR Cite
NPRM	04/12/85	50 FR 14397
NPRM Comment Period Begin	04/12/85	
NPRM Comment Period End	06/11/85	
Final Action	12/00/85	

Small Entity: No

Agency Contact: Roy Trudel, Program Analyst, Department of Health and Human Services, Health Care Financing Administration, Division of Medicaid Eligibility Policy, Room 416 EHR, 6325 Security Blvd., Baltimore, MD 21207, 301 594-9128

RIN: 0938-AB62

697. MEDICARE/MEDICAID REVALUATION OF ASSETS

Significance: Regulatory Program

Legal Authority: PL 98-369, Sec 2314; 42 USC 1395x

CFR Citation: 42 CFR 405.414; 42 CFR 405.415; 42 CFR 447.250; 42 CFR 447.253; 42 CFR 447.272

Abstract: This regulation would implement section 2314 of Pub.L. 98-369.

Section 2314 of P.L. 98-369 imposes new limitations on the valuation of assets acquired as the result of changes in ownership occurring on or after July 18, 1984. These changes would affect hospitals and skilled nursing facilities under the Medicare program and hospitals, skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded under the Medicaid program. These changes are intended to promote economy in the Medicare and Medicaid programs.

Timetable:

Action	Date	FR Cite
NPRM	11/00/85	
Final Action	04/00/86	

Small Entity: Undetermined

Agency Contact: Bruce Oliver, Program Analyst, Department of Health and Human Services, Health Care Financing Administration, Division of Audit and Payment Policy, Room 1-H-5 ELR, 6325 Security Blvd., Baltimore, MD 21207, 301 594-5892

RIN: 0938-AB64

INCOME AND ELIGIBILITY VERIFICATION

Significance: Agency Priority

Legal Authority: 42 USC 1320b-7

CFR Citation: 42 CFR 431.300; 42 CFR 431.305; 42 CFR 431.306; 42 CFR 431.800; 42 CFR 431.804; 42 CFR 435.910; 42 CFR 435.912; 42 CFR 435.917; 42 CFR 435.920; 42 CFR 435.940; 42 CFR 435.945; 42 CFR 435.950; 42 CFR 435.960; 42 CFR 435.965; 42 CFR 435.948; ...

Abstract: This rule requires State Medicaid agencies to verify the social security numbers of their recipients and to exchange and use information from other Federal and State agencies to verify income and eligibility information on recipients.

Timetable:

Action	Date	FR Cite
NPRM	03/14/85	50 FR 10450
NPRM Comment Period Begin	03/14/85	
NPRM Comment Period End	04/29/85	
Final Action	10/00/85	

Small Entity: No

Agency Contact: Joyce Somsak, Office Director, Department of Health and Human Services, Health Care Financing Administration, Office of Quality Control Programs, Room 2071 ELR, 6325 Security Blvd., Baltimore, MD 21207, 301 597-1354

RIN: 0938-AB73

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704. STANDARDS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Significance: Regulatory Program

Legal Authority: 42 USC 1302; 42 USC 1396d(c); 42 USC 1396d(d)

CFR Citation: 42 CFR 435; 42 CFR 442

Abstract: This rule would revise the standards for intermediate care facilities for the mentally retarded and persons with related conditions. It is intended to shift the focus away from facility oriented requirements to client-oriented requirements. Thus, the rule is designed to increase the focus on the provision of active treatment services for clients, clarify Federal requirements, and maintain essential client protection.

Timetable:

Action	Date	FR Cite
NPRM	10/00/85	

Small Entity: No

Agency Contact: Samuel Kidder, Branch Chief, Department of Health and Human Services, Health Care Financing Administration, Long Term Care Branch, Room 300 EHR, 6325 Security Blvd., Baltimore, MD 21207, 301 597-5909

RIN: 0938-AB76

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708. MEDICAID ELIGIBILITY--QUALITY CONTROL

Significance: Regulatory Program

Legal Authority: 42 USC 1396b

CFR Citation: 42 CFR 431.800-804; 42 CFR 431.810-822; 42 CFR 431.830-836; 42 CFR 431.901-904

Abstract: Under current regulations, States are allowed to rebut their quarterly projected error rate with more recent MEQC data. However, this rebuttal process underestimates the true error rate. Therefore, we are considering a revision of the regulations to eliminate the rebuttal process. Further, amendments that we are proposing would clarify the basic operating MEQC program functions and modify other MEQC program elements. We also plan to revise the criteria under which States may make good faith waiver requests. Waiver requests submitted after final regulations are in place will be reviewed under the new criteria regardless of the error rate period for which the waiver is being requested. Waivers will not be permitted for periods for which waivers were requested under prior waiver criteria.

Timetable:

Action	Date	FR Cite
NPRM	11/00/85	

Small Entity: No

Agency Contact: Joyce Somsak, Director, Office of Quality Control Programs, Department of Health and Human Services, Health Care Financing Administration, Bureau of Quality Control Programs, 207-L ELR, 6325 Security Blvd., Baltimore, MD 21207, 301 597-1354

RIN: 0938-AB85

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710. MEDICAID: IDENTIFICATION OF THIRD PARTY RESOURCES

Significance: Regulatory Program

Legal Authority: 42 USC 1396a(25)

CFR Citation: 42 CFR 433.138

Abstract: This regulation would provide that States use all available means to identify and collect third party resources. It would provide for cross referral between claims processing and recovery components within the State agency. These measures would improve program efficiency and reduce Medicaid expenditures through increased third part savings in those States that have not consistently pursued third party resources.

Timetable:

Action	Date	FR Cite
NPRM	10/00/85	
Final Action	02/00/86	

Small Entity: Undetermined

Agency Contact: Gale Held, Division Director, Department of Health and Human Services, Health Care Financing Administration, Division of Operational Initiatives, Rm. 367 ME, 6325 Security Blvd., Baltimore, MD 21207, 301 594-9101

RIN: 0938-AB88

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713. ● PRESCRIPTION DRUG REIMBURSEMENT

Significance: Regulatory Program

Legal Authority: 42 USC 1396(b)(i)(1); 42 USC 1396a(a)(30)

CFR Citation: 45 CFR 19.1 to 19.6; 42 CFR 447.331 to 334

Abstract: A proposed rule is being developed which would revise the method for setting limits on Federal matching payments under Medicaid for drugs. Current reimbursement for prescription drugs is limited to the lowest of (1) the estimated acquisition cost plus a reasonable dispensing fee, (2) the usual and customary charge for the prescription, or (3) for certain drugs available from multiple sources, the maximum allowable cost plus a reasonable dispensing fee. The regulations have been reviewed to determine their effects.

Timetable:

Action	Date	FR Cite
NPRM	03/00/86	

Small Entity: Yes

Agency Contact: Judy Boggs, Special Assistant to AAP, Department of Health and Human Services, Health Care Financing Administration, Rm 325H HHH Bldg., 200 Independence Ave., SW, Washington, DC 20201, 202 245-7982

RIN: 0938-AB97

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717. ● MEDICAID COVERAGE OF QUALIFIED PREGNANT WOMEN AND CHILDREN AND NEWBORN CHILDREN

Legal Authority: PL 98-369, Sec 2361; PL 98-369, Sec 2362

CFR Citation: 42 CFR 435.3; 42 CFR 435.115; 42 CFR 435.116; 42 CFR 435.117; 42 CFR 435.301; 42 CFR 436.2; 42 CFR 436.114; 42 CFR 436.120; 42 CFR 436.122

Abstract: These regulations would conform the Medicaid regulations to statutory changes made by the Deficit Reduction Act of 1984 by adding two mandatory eligibility groups of individuals: qualified pregnant women and children under age 5 and certain newborn children. States have been advised previously that the statute is self-implementing. Additionally, a manual instruction containing procedures for States to implement these requirements was issued to States. However, these regulations are necessary to conform the Medicaid regulations to statutory changes.

Timetable:

Action	Date	FR Cite
NPRM	10/00/85	

Small Entity: No

Agency Contact: Richard Strauss, Program Analyst, Department of Health and Human Services, Health Care Financing Administration, Office of Eligibility Policy, Rm. 416 EHR, 6325 Security Blvd., Baltimore, MD 21207, 301 594-6529

RIN: 0938-AC02

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725. ● PATIENT CARE AND SERVICES (PACS) SURVEY PROCESS

Significance: Agency Priority

Legal Authority: 42 USC 1302

CFR Citation: 42 CFR 405; 42 CFR 442

Abstract: The Court of Appeals for the Tenth Circuit ruled that the Secretary of HHS has a duty to establish an enforcement system which will adequately inform her, on a continuing basis, whether nursing homes receiving Federal Medicaid funds are actually providing high quality medical care. The primary proposal under consideration is nationwide implementation of the Patient Care and Services (PaCS) survey process. The PaCS survey would: provide continuing information on whether nursing homes are providing quality care; and, would be used as an enforcement mechanism to terminate participation of those facilities that do not maintain high quality care. This change would be implemented through the rulemaking process.

Timetable:

Action	Date	FR Cite
NPRM	10/00/85	

Small Entity: Yes

Agency Contact: Sharon Harris, Office Director, Department of Health and Human Services, Health Care Financing Administration, Office of Survey and Certification, Rm. 2-A-5 ME, 6325 Security Blvd., Baltimore, MD 21207, 301 594-5547

RIN: 0938-AC10

Medicaid Information and Assistance Project (MIAP)

a project of the American Public Welfare Association

MIAP BULLETIN

No. 8
December 1985

FEDERAL REGISTER HIGHLIGHTS

Medicaid and Supplemental Security Income: Eligibility to Severely Impaired Individuals Who Perform Substantial Gainful Activity; 20 CFR 416 and 42 CFR 435
Final Rule; November 13, 1985

This final rule amends sections 201(a) and (b) of PL 96-265 by extending the expiration date of a section 1619 (of the Act) demonstration project established by this section. Section 201, one of several work incentive provisions included in PL 96-265, allowed certain individuals who lost SSI benefits, based on either their disability or their work earnings, to retain elgibility for Medicaid.

This demonstration was enacted to gather information regarding the characteristics of those who would benefit from such a program and to assess the impact of such a program on reducing work disincentives for the disabled. The demonstration originally was scheduled to terminate on December 31, 1983 and this rule extends the expiration through June 30, 1987 and is retroactive to January 1, 1984. The program was extended to allow collection of additional data on the effects of the provisions.

Medicaid Program: Coverage of Qualified Pregnant Women and Children and Newborn Children; 42 CFR Parts 435 and 436
Proposed rule with comment period; November 21, 1985

This proposed rule, reflecting statutory changes made under the Deficit Reduction Act of 1984 (DEFRA) adds sections to the Medicaid regulations regarding the mandatory eligibility of: (1) qualified pregnant women; (2) certain children under age 5; and (3) newborn children of Medicaid-eligible women.

A qualified pregnant woman, as defined in section 2361 of DEFRA, is one whose pregnancy has been medically verified and who (a) would be eligible or deemed eligible for AFDC cash benefits if the child had been born to her and living

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with her in the month of payment; or (b) would be eligible or is a member of a family that would be eligible for AFDC cash payments if the state's AFDC plan included an unemployed parents program. The provisions for the mandatory coverage of qualified pregnant women apply as of October 1, 1984.

Section 2361 of DEFRA also adds a mandatory eligibility category for qualified children under age 5, defined as those born after September 30, 1983 and who meet the income and resource requirements of the state's approved AFDC plan. This phase-in of mandatory coverage for all qualified children under age 5 does not alter the coverage group of optionally categorically needy children under age 21 (or 20, 19, or 18) also referred to as "Ribicoff" children.

Section 2362 of DEFRA establishes a specific requirement for Medicaid eligibility for certain newborn children and provides that a child born on or after October 1, 1984 to a woman eligible for and receiving Medicaid at the time of the child's birth is deemed to have filed an application and found eligible for Medicaid on the date of birth and remains eligible for one year as long as the woman remains eligible and the child remains in the woman's household.

Comments on this proposed rule must be received by HCFA by January 21, 1986.

COURT CASES

Issue: **Reimbursement for nursing home services**
New York Supreme Court, Appellate Division, Third Judicial Department. No. 49736, October 31, 1985.

This appeal by the state of procedural and reimbursement issues related to nursing home services included the following five areas:

1) Time limitation for correction of rates.

   The court ruled that the state's denial of the provider's request for a rate correction beyond the 120 day time limit for filing such requests was neither arbitrary nor capricious and upheld the state's action.

2) Reimbursement of salary costs.

   The provider argued that a change in state reimbursement policy, which placed a ceiling on reimbursement of both "administrative" and "non-administrative" senior management salaries was invalid due to the state's failure to provide prior notification of the change in policy.

The court found the reimbursement change did not require issuance as a regulation nor did it require prior notification before implementation.

3) Reimbursement of movable equipment.

According to the court's findings, state law required promulgation of a regulation in order for a ceiling to be imposed on reimbursement for movable equipment. Since the state did not do this, application of the ceiling was not valid.

4) Refusal to increase provider's base year property costs.

The state's rate review officer's refusal to increase the provider's base year property costs was found to be arbitrary and capricious and the court required an administrative hearing be held on this issue.

5) Bad debt expenses.

The court ruled that, in order to have the provider's bad debt claim allowed, the provider must show that the claims in question were related to covered services and reasonable efforts had been made to collect.

Issue: Coverage of electronic speech devices.
U.S. Court of Appeals, Eighth Circuit. No. 85 - 1070, November 4, 1985.

The court, in the case, addressed two issues related to electronic speech devices: (1) whether it was a covered service under Iowa's state Medicaid plan; and (2) if so, which type of device is the state required to cover. The plaintiff, an SSI recipient, upon recommendation of the speech pathologist, was prescribed an electronic speech device. The Iowa Medicaid program denied a request for the device arguing it was not a covered service under its program. The court determined, however, that the state's Medicaid plan includes the optional service of "physical therapy and related devices" and was subsequently bound by the federal regulations which govern coverage of these services. The regulations include coverage of equipment, provided under the direction of a speech pathologist, necessary to correct a speech disorder. The court ruled that Iowa must cover this service under its Medicaid program.

The question of which type/model of device is appropriate for coverage in this case was remanded to the district court for further development of the factual issues.

GRANT APPEALS BOARD DECISIONS

Issue: Disallowance of claims for increasing adjustments filed after the two-year deadline.
Pennsylvania Department of Public Welfare, Decision No. 703, November 19, 1985.

The state received disallowances for claims filed after the two-year filing deadline. The claims were for increasing adjustments to interim payments made to publicly-owned facilities. Original claims for the interim rate had been filed within the two year time limit. The Health Care Financing Administration (HCFA) did not allege that the claims were otherwise unallowable but did allege that the claims had not been filed on time. The Board found that HCFA's position failed to consider the nature of the interim rate system under which adjustments to interim payments are not restricted by the two-year time limit for filing. The Board referring to a similar grant appeals board decision, Pennsylvania Department of Public Welfare, Decision No. 603, December 12, 1985, overturned the disallowances.

Issue: Disallowance for failure to conduct annual medical care review.
Kentucky Division of Medical Assistance, Decision No. 704, November 20, 1985

The state received disallowances for nine patients in two IMDs and two ICFs/MR. All nine patients had been determined at the time of the reviews to be financially eligible to receive Medicaid benefits but had not been determined as eligible for Medicaid institutional benefits. Since 1980, the state had not been conducting annual medical care reviews of patients whose eligibility for Medicaid institutional benefits had not yet been determined. The State argued that such reviews were not required for these patients. The Health Care Financing Administration (HCFA) argued that annual reviews are required for all Medicaid-eligibles. The Board concluded that statutory and regulatory provisions were unclear regarding the requirement that annual reviews be conducted for patients whose eligibility for institutional benefits was not yet determined. Further, the Board found that the record supports the view that the state would have conducted the reviews if it had known the reviews were required. The Board, in this case, overturned the disallowance but noted that HCFA could, in the future and with notice, require an annual review of Medicaid eligibles in institutions whose eligibility for institutional benefits has yet to be determined.

Issue: Reduction of Federal Financial Participation (FFP) for services provided during the partial months of patient's admission to or discharge from Institutions for Mental Diseases (IMDs)
Washington State Department of Social and Health Services, Decision No. 709, November 27, 1985

The State received a disallowance for services provided to individuals during the patients' month of admission to or discharge from an IMD. Generally services to IMD patients aged 22-64 are not eligible for FFP. During the time period in question (June 1980 and June 1982) an exception to that rule was in effect: "FFP is available in expenditures for services furnished to eligible individuals during the month in which they become... patients in an institution for mental diseases (42 CFR 435. 1008 (b))". (This rule was later amended to prohibit FFP for IMD services to person aged 22-64 during the patient's month of admission and discharge (See MIAP Bulletin, No. 1 May, 1985, Federal Register Highlights, April 3, 1985). The Board ruled that this IMD coverage exception did not authorize FFP for the full per diem cost of the IMD, but rather authorized payment only for services otherwise covered in Washington's Medicaid State Plan. The State showed that certain services provided to these patients in IMDs were covered by its State Plan and received a reduction in the disallowance. A subsequent appeal by the State for further reduction of the disallowance failed because the Board ruled that the services in question were not covered by the state plan.

OF NOTE

"State Programs of Assistance for the Medically Indigent"
Intergovernmental Health Policy Project, George Washington University, November, 1985.

This publication provides an overview of the medically indigent problem, including its causes and a description of the characteristics of the medically indigent. The heart of the report profiles each state's indigent care program. The report describes statewide programs that are designed to assist the medically indigent and are administered or funded wholly or in part by the state government. The profile of a state's program includes a description of the following components: eligibility standards; administrative responsibilities; benefit coverage; source of funding; recipient counts; and total expenditures. The state profile also describes other state programs or policies that assist the medically indigent in obtaining necessary medical care.

Medicaid directors will automatically be sent a copy of this report.

For further information, please contact:

Randy Desonia
Intergovernmental Health Policy Project
2100 Pennsylvania Ave, N.W., Suite 616
Washington, D.C. 20037
(202) 872-1445

"State Reimbursement Policies for Privately-Operated Intermediate Care Facilities for the Mentally Retarded - 1984"
Center for Residential Services, University of Minnesota
(Published by the State Medicaid Information Center, National Governors' Association - Available for a cost of $10.00, prepaid)

This document describes and analyzes state policies for reimbursing Medicaid ICF/MR services: describing in detail the reimbursement methods in five case study states. The final section explores how state rate-setting policies could be used to control costs, encourage efficiency and enhance quality. Recommendations are provided to assist states in achieving these objectives.

For further information, please contact:

Publications Office
National Governors' Association
444 No. Capitol Street
Washington, D.C. 20001
(202) 624-7880

COMING EVENTS

"Capitated Rates and Medicaid"
National Governors' Association
January 22-24, 1985
The Queen Mary Hotel
Long Beach, California

The National Governors' Association will host a conference on issues related to the capitation of the Medicaid population for primary care services. The topics to be discussed are: the cost of developing and maintaining a capitated arrangement; rate calculation; risk-sharing and stop-loss options; federal requirements and oversight; encounter data; and documenting quality under capitation.

The conference will begin on the afternoon of January 22, 1985.

For further information, please contact:

Karen Squarrell
Health Policy Studies
National Governors' Association
444 No. Capitol Street
Washington, D.C. 20001
(202) 624-5348

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MIAP BULLETIN

No. 10
February 1986

FEDERAL REGISTER HIGHLIGHTS

Medicaid Program: Eligibility in the States, District of Columbia and the Northern Mariana Islands: 42 CFR 435
CFR Correction; January 31, 1986

Section 435.732 on page 98 of the October 1, 1985 revision of Title 42 of the Code of Federal Regulations was omitted. Section 435.732, dealing with procedures for determining income eligibility, is reproduced in this issue of the Federal Register.

COURT CASES

Issue: **Medical Lien Against Wrongful Death Settlement**
California Court of Appeal, Fifth Appellate District. No. F004812, November 6, 1985.

At issue in this case is whether the state can recoup from a wrongful death settlement medical expenses provided to the decedent and paid for by the state's Medicaid program (Medi-Cal). The case involves a woman who entered a hospital for treatment of asthma and due to negligent care received in the hospital, suffered severe brain damage and dementia, forcing her to live in state hospitals for 2 years, until her death. After her death, the patient's heirs, her husband and 11-year-old son, successfully sued the hospital and physician who treated her. The state's Department of Health Services (Medi-Cal) placed a lien against the settlement for reimbursement for services paid by the Medi-Cal program. The plantiffs argued that such a lien was illegal based upon a provision in California law which prohibits medical liens against estates in the event that the recipient was under age 65 when the services were rendered or when there is a surviving spouse or minor child. The court ruled that a medical lien was allowable in this case because the wrongful death settlement was not part of the decedent's estate.

The MIAP Bulletin is published with support by a contract (No. 500-86-0013) awarded to APWA by the Health Care Financing Administration (HCFA), the U.S. Department of Health and Human Services (HHS).

Issue: FFP for rehabilitative training in ICFs/MR
U.S. District Court, District of Massachusetts. Civil Action No. 85-2337-G, November 23, 1985.

This case, in which Masssachusetts requested and was granted a summary judgement, presents virtually the same legal and factual issues which were addressed in a previous ruling by the Court. In the prior case (U.S. District Court, District of Massachusetts, Civil Action No. 83-2523-G, August 27, 1985 - see MIAP Bulletin No. 6, October 1985), the court ruled that "habilitative" services, designed to assist ICF/MR patients in attaining the capability for self-care, are covered by Medicaid even though these same services may be included in the patients' "individual education plan." The current case differs only with respect to the time period for which a ruling is requested. The court found in favor of the state and overturned the Grant Appeals Board disallowance (see GAB decision No. 638 - MIAP Bulletin No. 3, July 1985) of $4,908,944 for the period January 1, 1981 through June 30,1982.

Issue: Providers engaging in fraud against the Medicaid program
U.S. District Court for the Northern District of Illinois, Eastern Division, Case No. 84-CR-129, January 22, 1986.

On January 22, 1986, the court convicted a number of pharmacists and physicians, some doing business as Drug Industry Consultants (DIC), Inc., for fraud against the Medicaid program in Illinois. As a result of a tip in 1981 from a Medicaid client, the Illinois Department of Public Aid, in cooperation with the U.S. Attorney's Office, the Illinois State Police and the U.S. Postal Inspectors, began a lengthy investigation into providers suspected of defrauding the Medicaid program. During the course of the investigation, it was determined that these providers were involved in a scam involving the disbursement of a codeine-based cough syrup to drug addicts who were also Medicaid recipients. In return, the addicts allowed the defendants to submit fraudulent claims for services allegedly provided them but not actually performed.

The state estimates approximately $19.7 million was illegally obtained from the Medicaid program as a result of this fraud case. Sentencing of the convicted providers will take place March 31, 1986 at which time the court will decide the dollar amount of the judgement against the providers.

GRANT APPEALS BOARD DECISIONS

Issue: Disallowances for excess payments to providers
Arkansas Department of Human Services, Decision No. 717, January 8, 1986

This Grant Appeals Board case, on remand from the U.S. District Court for the Eastern District of Arkansas, upholds HCFA's decision to disallow payments for providers determined to have been reimbursed in excess of amounts allowed under the Arkansas State Plan. In this fairly complex case, the state did not deny, per se, that the providers in question received excess payments but did advance a number of reasons why HCFA should be precluded from recovering these overpayments. These arguments, in the form of questions, included:

- "Does section 1903(d)(3) of the Social Security Act preclude HCFA from adjusting the federal share of excess payments which the State has not recovered from the providers?"

- "Is HCFA precluded from taking this disallowance because HCFA approved the State plan provision establishing a provider appeals process?"

- "Does the partnership concept in the Medicaid program require that HCFA establish that the State was at fault in making the excess payments to the providers or in failing to recover them?"

- "Is HCFA precluded from taking this disallowance based on the theory of equitable estoppel because of HCFA's actions or inactions related to development and implementation of the State's system for reimbursing providers?"

- "Did HCFA improperly use 1977 cost data in calculating some of the excess payments?"

The Board ruled in each case that the above arguments did not preclude HCFA from collecting the federal share of overpayments and upheld the disallowance.

Issue: Effect of DEFRA amendments to Section 1903 (g) - certifications and annual patient reviews in ICFs and SNFs.
Wyoming Department of Health and Social Services, Decision No. 719, January 23, 1986

In this case, the Health Care Financing Administration disallowed Medicaid payments to the state for quarters ending

March 31, 1984, June 30, 1984 and September 30, 1984 for its failure to properly recertify patients in ICFs and SNFs and failure to provide annual medical reviews. The state conceded both these failures but argued that the amendments to section 1903(g) made by the Deficit Reduction Act (DEFRA) of 1984 changed those provisions related to recertification on which some of the disallowances were based.

The Board in its decision ruled on several different aspects of the case. For the quarters prior to the July 1, 1984 effective date of DEFRA, the Board found that the state was, in fact, required to recertify patients and conduct annual medical reviews and, since it did not do so, upheld these disallowances. The Board did conclude, however, that the DEFRA amendments changed the penalty provisions involving certifications and thus overturned the disallowances for the quarter ending September 30, 1984 as the basis for this disallowance no longer existed. The disallowances for failure to conduct annual reviews were upheld for the quarter ending September 30, 1984 as DEFRA did not alter this specific provision.

STATE MEDICAID MANUAL AND HCFA PROGRAM MEMORANDUM

State Medicaid Manual
Part 7 - Quality Control
Transmittal No. 32 - December 1985

This transmittal reorganizes Chapter 3 of Part 7 which addresses the Medicaid Eligibility Quality Control (MEQC) Review process. Included are revisions to Medicaid eligibility coverage codes resulting from provisions in the Deficit Reduction Act of 1984 (P.L. 98-369).

HCFA Program Memorandum - Medicaid State Agencies
Transmittal No. 85-19 - January 1986
RE: Suspended/Excluded Health Care Providers

This notice contains information, provided by the Office of Inspector General, on provider terminations, suspensions, withdrawls and reinstatements for the period October 1-31, 1985.

HCFA Program Memorandum - Medicaid State Agencies
Transmittal No. 85-20 - January 1986
RE: Treatment of Title II cost-of-living increases (COLAs)

This transmittal issues instructions regarding the treatment of Title II COLAs resulting from the U.S. District Court's

interpretation of the "Pickle Amendment" (Section 503 of P.L. 94-566) through the case of Lynch vs. Rank. The methodology for deducting Title II COLAs, including those of all financially responsible family members regardless of Medicaid eligibility status, is described.

OF NOTE

"State Reimbursement Policies for Privately Operated Intermediate Care Facilities for the Mentally Retarded (ICFs/MR): 1984"
Steven Clauser, Lisa Rotegard and Carolyn White; Center for Residential Services, University of Minnesota; November 1985.

This paper examines state methodologies for setting payment rates for private ICF/MR residential care. These private facilities are the focal point of this report due to both their rapid growth and the fact that their costs, unlike those of large publicly-operated ICFs/MR, are more directly effected by formal reimbursement methodologies.

A brief history of Medicaid ICF/MR reimbursement policy is presented as well as an overview of state payment system methodologies including five detailed case studies. The final section of the paper examines how state reimbursement policies can potentially control costs while enhancing the quality of care in private ICFs/MR.

For further information, please contact:

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State Medicaid Information Center
National Governors' Association
444 No. Capitol Street
Washington, D.C. 20001
(202) 624-7812

"Federal Benefit Programs:A Profile"
U.S. General Accounting Office (HRD 86-14), October 17, 1985

This document profiles 150 benefit programs that provide cash or noncash assistance to persons demonstrating need or who qualify for benefits as a result of either (1) contributions made by them or on their behalf or (2) military service. As a profile, the document identifies the 150

programs and, for 91 selected programs, it (1) provides financial and other related data; (2) describes their purposes, who is eligible for them, and the benefits available; and (3) identifies the federal agencies that administer them and the congressional committees that oversee them.

For copies of the report, please contact:

U.S. General Accounting Office
Document Handling and Information Services Facility
P.O. Box 6015
Gaithersburg, Maryland 20877
(202) 275-6241

"Addressing Health Care for the Indigent: State Initiatives 1985"
National Governors' Association (NGA), Health Policy Studies and the Intergovernmental Health Policy Project (IHPP), November 1985

This publication is a follow-up to the 1984 NGA/IHPP document titled "A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent." Like that document, this report identifies and describes the breadth of activity in states that have either enacted or implemented policy initiatives or created task forces to study the issues of access to health care for the medically indigent. The information in this report, however, summarizes these state actions which took place in 1985. In addition to the state summaries, a number of observations concerning state approaches to the indigent health care issue are also noted.

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COMING EVENTS

"National Debate on Health Care"
Dallas, Texas
April 20-23, 1986

This "National Debate", hosted by the Texas Department of Human Services, the Office of the Governor of Texas, and

several other Texas agencies, will raise five pressing questions concerning current health care issues. Leaders from both the public and private sector will use these questions as a focal point to identify problems, give their points of view, and discuss possible solutions.

For further information, please contact:

Roy Westerfield
Symposium Director
P.O. Box 49287
Austin, Texas 78765
(512) 450-3008

State Medicaid Directors' Association Conference
(Co-Sponsored by the State Medicaid Directors' Association and the Office of Intergovernmental Affairs, Health Care Financing Administration)
Denver, Colorado
May 12-14, 1986

This conference will begin on May 12, 1986 with a closed session meeting of the State Medicaid Directors' Association. The remaining days, May 13-14, 1986 will be open to the public.

For further information, please contact:

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(202) 245-6258

"National SURS Conference"
National Association of Surveillance Officers
St. Paul, Minnesota
June 15-19, 1986

The National SURS Conference is the annual meeting for the National Association of Surveillance Officers. The members of the Association perform the Surveillance and Utilization Review (SURS) function in the state Medicaid programs. The SURS activity focuses on post-payment review of health services reimbursed by the Medicaid program. Review activities include investigation for fraud and abuse and review of claims for quality and medical necessity issues.

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